PSYCHOTRAUMATIC ENTITLEMENT

The Worker's Compensation Board

and

The Ombudsman's Experience

March, 1988

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THE OMBUDSMAN'S EXPERIENCE

MARCH 1988

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PSYCHOTRAUMATIC ENTITLEMENT

THE WORKERS' COMPENSATION BOARD AND THE OMBUDSMAN'S EXPERIENCE

INTRODUCTION

By their very nature, Workers' Compensation Board claims involving psychotraumatic work injuries are more complex than claims related only to physical injury. While the Board has accepted the legitimacy of psychotraumatic entitlement and, therefore, the responsibility for its adjudication, the process is often a problematic one. This paper intends to review Board policies and practices on the issue by focusing on the 175 jurisdictional[1] cases involving psychotraumatic entitlement which were brought to this Office between 1977 and March of 1986.[2] Of that number, 122 files contained either a report or a fact summary sufficiently detailed to allow for examination.

In the ten plus years that our Office has been investigating Workers' Compensation Board cases, much has changed. For a proper, historical framework to Board legislation and policy, the appeals system and Ombudsman involvement, the reader may wish to consult the appendices. While some of the background material is now dated, it remains essential for an understanding of the present situation.

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[1] "Jurisdictional" means those cases where all levels of appeal had been exhausted prior to coming to our Office.

[2] A record of files closed before 1977 was not available.

Some of the problems, however, have been consistent over the years. This report will survey the major contentious issues which have arisen from the 122 case studies:

1) difficulties with the Board's procedures and policies for entitlement;

2) the reasoning behind denying entitlement;

3) instances where entitlement was granted but dissatisfaction existed with the percentage of the disability award; and

4) whether or not entitlement should be provisional or permanent.

Out of the review there have come some recommendations which, it is hoped, will help make the adjudicative process more just and more equitable for all concerned when a psychotraumatic disability arises from a work injury: for the employer who provides financial and documentary support for the system; for the Board which is responsible for determining what benefits can be paid; and, for the worker whose health and happiness have been adversely affected.

PSYCHOTRAUMATIC COMPLAINT PROFILE

The number of jurisdictional complaints to the Ombudsman as of March 1987 has surpassed 40,000 and, of these, complaints regarding the Workers' Compensation Board are close to 5,000. (See Table 1.) Of that number, 175 files identified as including a psychotraumatic component were selected from our records and reviewed. Of the 175 files, 122 contained reports sufficiently detailed to allow for a retrospective look at who these people were, and how they came to be dissatisfied with the Board's decisions.

The Representative Complainant

It may be useful to describe a person representative of those who have complained to the Ombudsman about the Board's handling of claims with psychological factors, and what happened to the complaints. The statistically average complainant is a man who injured his back and, within one year of the accident, demonstrated a psychological problem related to the accident. During the course of evaluation, he was seen by both a Board and an independent psychiatrist who diagnosed a depressive neurosis. The worker was unsuccessful in attempts to have the psychotraumatic disability recognized by the Board because it was of the opinion that his personality makeup was the real cause of the disability. He was unsuccessful as well in gaining the Ombudsman's support unless, generally, the preponderance of medical evidence was in his favour.

TABLE 1

TOTAL JURISDICTIONAL COMPLAINTS AND JURISDICTIONAL

WORKERS' COMPENSATION BOARD COMPLAINTS

OFFICE OF THE OMBUDSMAN

1975/76 - 1986/87

	Jurisdictional Complaints	Jurisdictional WCB Complaints
1975/76	954	--
1976/77	1,827	164
1977/78	2,256	322
1978/79	2,869	276
1979/80	2,354	264
1980/81	3,602	726
1981/82	2,166	522
1982/83	2,764	627
1983/84	5,563	754
1984/85	5,366	565
1985/86	5,235	419
1986/87	5,897	352
TOTAL:	40,853	4,991

Source: Annual Reports of the Ombudsman, 1975/76 to 1986/87.

Characteristics

Gender

In the 122 cases reviewed for this paper, there were almost three times as many men (90) as women (32). This may reflect higher participation by men in dangerous or strenuous work rather than any other sex-based difference. (See Table 2.)

Area of Injury

In the 122 cases reviewed, 146 injuries were documented since some complainants had incurred multiple injuries. The back and neck were the body parts most frequently injured (84). Following far behind were the upper extremities, that is, hand, fingers, elbow, shoulder or entire arm at 22, and the lower extremities at 18. Some reports in the medical literature have found head injury to be highly represented in populations suffering psychotraumatic problems, possibly because of the symbolic value of the head but, of the 146 injuries documented here, only 10 were to the head. In 3 cases the chest was injured. Stress was felt to be the presenting injury by 4 of the complainants, and burns by 2. Hernia, inhalation of toxic fumes and no physical injury were each involved in one of the cases. (See Table 3.)

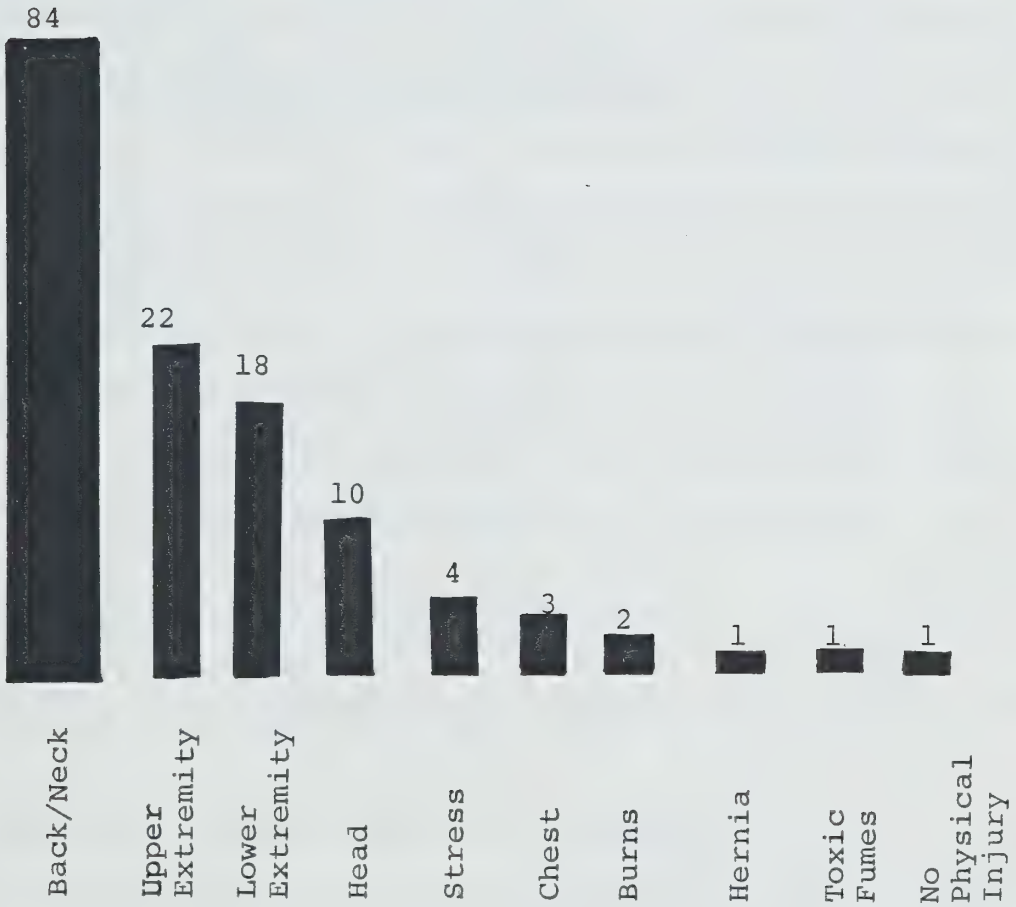
TABLE 2

GENDER OF 122 COMPLAINANTS

Source: Ombudsman's Records, 1977 to 1987.

TABLE 3

AREA OF INJURY



The total of 146 is greater than 122 because some workers injured more than one area.

Source: Ombudsman's Records, 1977 to 1987.

Psychiatric Diagnosis

Within the 122 cases, psychiatrists made 146 diagnoses, the most prevalent of which was depressive neurosis (34). Conversion reaction or hysteria was also highly represented at 27. Chronic, traumatic or post-traumatic neurosis was diagnosed 17 times and anxiety neurosis 16. The descriptive phrase, "psychiatric/functional/emotional problems", was present in 10 cases. One diagnosis not contained in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), compensation neurosis, accounted for 9 of the diagnoses made. "No psychiatric disability" was found in 6 cases. Adjustment, character or personality disorder accounted for only 5 of the diagnoses made, a low percentage considering the number of times "personality makeup" was relied on by the Board to deny entitlement. Diagnoses suggesting psychosis, alcoholism and malingering were made rarely. No diagnosis of post-traumatic stress disorder was made. (See Table 4.)

First Documentation of a Psychological Problem

Of the 122 cases reviewed, there was enough information in only 89 of the reports to determine the time lapse between the work injury or surgery and the first documentation of the psychiatric problem. In 50 of the 89 cases, a psychological problem became manifest within the first year; 17 in the second; 6 in the third; 7 in the fourth; and 3 in the fifth. All told, in 83 of the cases, the first manifestation of

TABLE 4

PSYCHIATRIC DIAGNOSES

Depressive neurosis	34
Conversion reaction or hysteria	27
Chronic, traumatic or post-traumatic neurosis	17
Anxiety neurosis	16
Psychiatric, functional or emotional problems	10
Compensation or accident neurosis	9
Psychogenic magnification, regional pain or fibrositis	7
No psychiatric disability	6
Adjustment, character or personality disorder	5
Alcoholism	4
Paranoia	3
Malingering	2
Psychosomatic reaction	2
Hypomania	1
Organic brain syndrome	1
Phantom pain syndrome	1
Schizophrenia	1
TOTAL*:	146

Source: Ombudsman's Records, 1977 to 1987.

*The total is greater than 122 because some workers had more than one diagnosis.

psychotraumatic disability was demonstrated within the Board's five-year policy guideline. The other 6 ranged between 6 and 21 years. (See Table 5.)

Psychiatric Evaluation

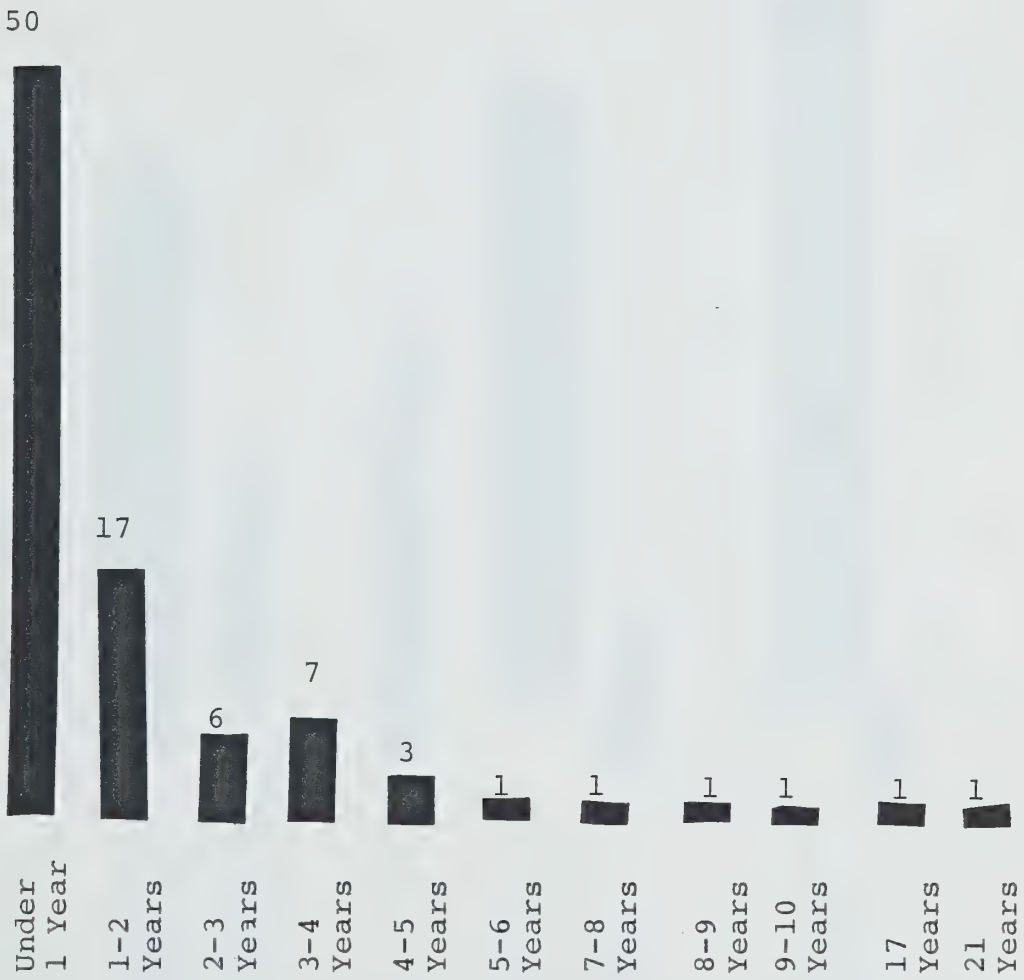
Once a psychological problem became apparent, all but 7 of the 122 complainants saw a psychiatrist, and many of them saw more than one. Psychiatrists performed evaluations on 207 occasions, private practitioners 99 times, and Board psychiatrists or consultants 81 times. The Committee for Assessment of Major Psychotraumatic Disability conducted 14 of the evaluations, and the Psychiatric Social Evaluation Module (PSEM) conducted 13. It would not appear that access to a psychiatrist has been an issue, although workers outside the major population centres might be restricted in their choice of whom they see. (See Table 6.)

Entitlement Sought

In 80 of the 122 cases reviewed, gaining recognition of a psychotraumatic disability related to a work injury was the major problem. Pensions accounted for the rest of the complaints, with 28 concerned with provisional awards, 10 with permanent awards, and 4 with the dating of awards. (See Table 7.)

TABLE 5

FIRST DOCUMENTATION OF A PSYCHOLOGICAL PROBLEM

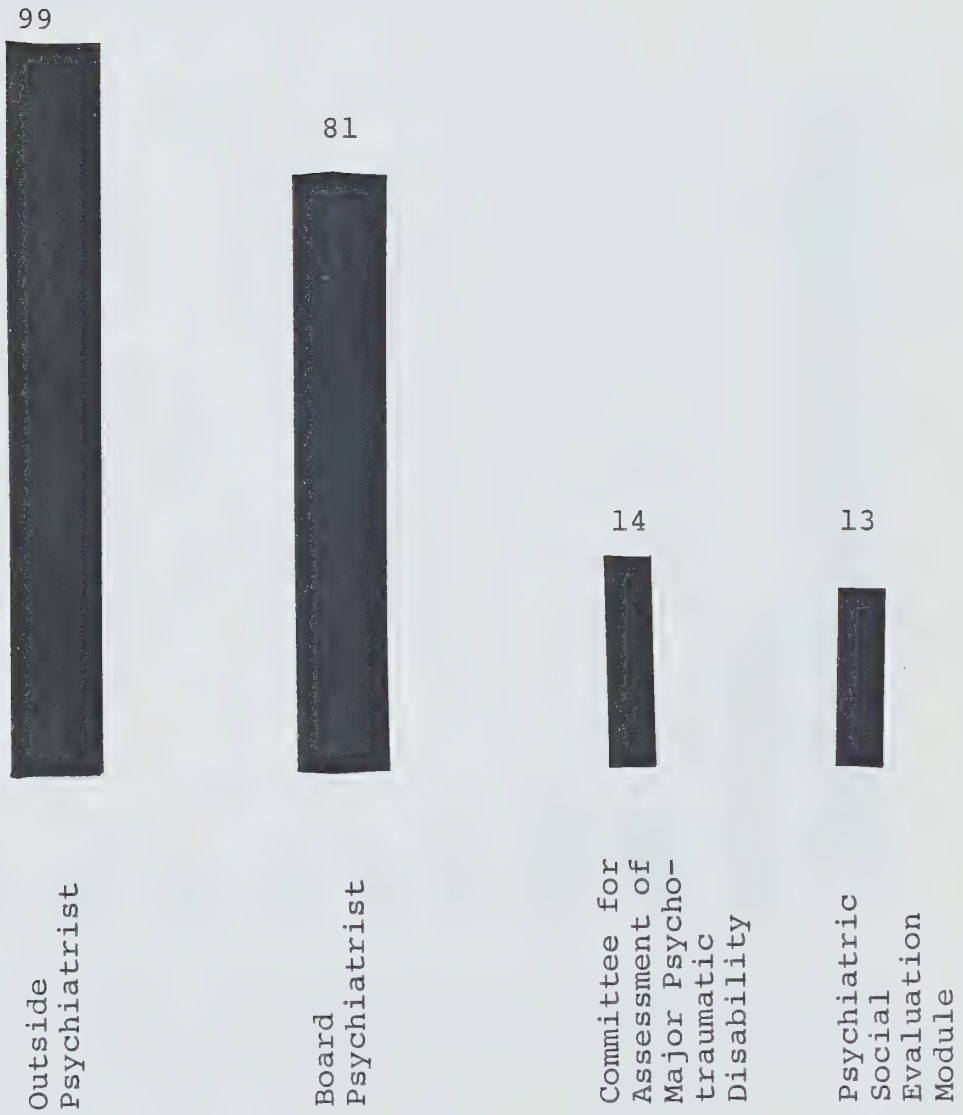


The total of 89 is less than 122 because not all reports contained sufficient information to determine the time lapse between accident or surgery and documentation of a psychiatric problem.

Source: Ombudsman's Records, 1977 to 1987.

TABLE 6

PSYCHIATRIC EVALUATION

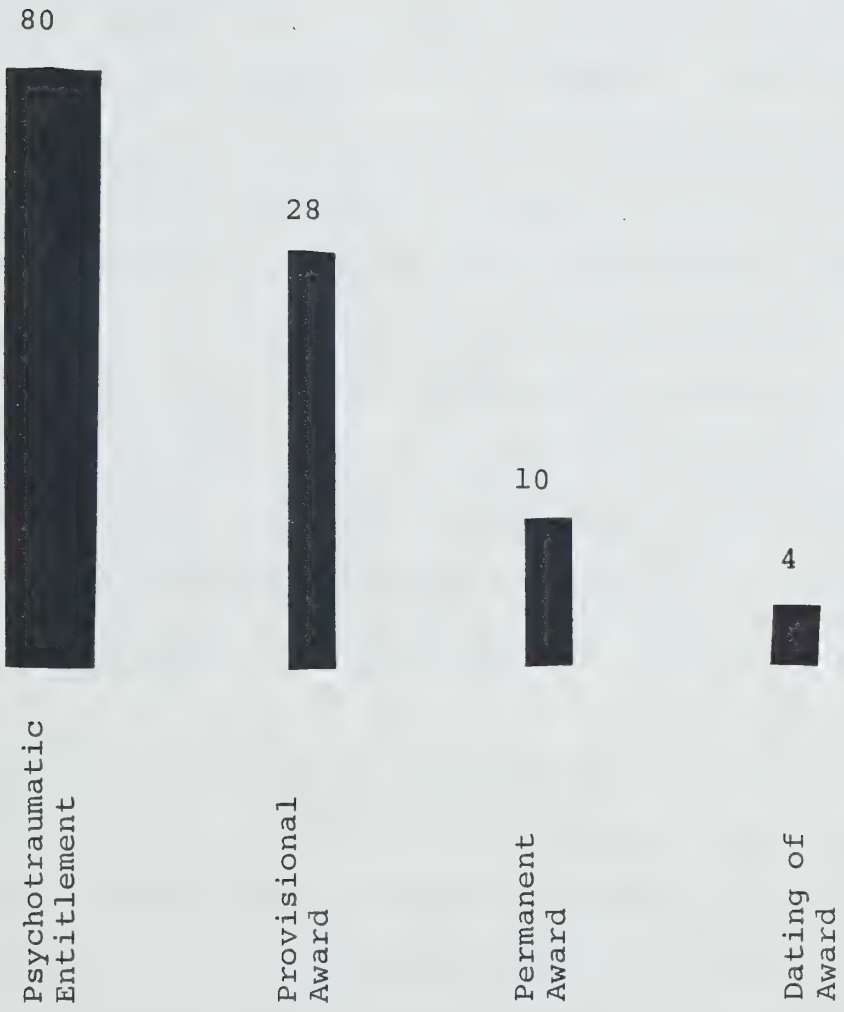


The total of 207 is greater than 122 because some workers had more than one psychiatric evaluation.

Source: Ombudsman's Records, 1977 to 1987.

TABLE 7

ENTITLEMENT SOUGHT



Source: Ombudsman's Records, 1977 to 1987.

Reasons for Denial of Entitlement

Review of the files showed that 228 reasons were given by the Board for finding no relationship between a work accident and the subsequent disability.

Personality-related factors were noted in 104 cases, with personality makeup relied on in 36. In 20 cases the Board found there was no psychiatric disability. A pre-existing disability and a feeling of injustice were each mentioned 13 times. Attitude was mentioned 6 times, with descriptive phrases such as exaggeration, magnification, overconcern with symptoms, limited motivation for recovery and limited coping capacity cited a further 12 times. Malingering was the reason given on 3 occasions and personality disorder once. The reliance on personality factors would seem to reflect the Board's view that, although every injury will be accompanied by some degree of anxiety, in most cases the anxiety will clear quickly and maintenance of a disability becomes a function of the basic personality rather than of the accident.

Stresses other than those associated with work accidents were considered to be reasons for finding no relationship between an accident and the disability 45 times. The most commonly cited, at 19, was family or marital stress. Non-compensable, psychosocial and environmental factors were seen in 11 cases. Another 12 factors ranged from conflict with employer (2) to varicose veins (one). Benefits derived from work

TABLE 8

REASONS FOR DENIAL OF ENTITLEMENT

Personality	
Makeup	36
No psychiatric disability	20
Pre-existing disability	13
Feeling of injustice	13
Attitude	6
Exaggeration/magnification	6
Malingering	3
Overly concerned with symptoms	3
Limited motivation for recovery	2
Limited coping capacity	1
Personality disorder	1
	104
Non-Accident Stresses	
Family/marital stress	19
Non-compensable factors	4
Psychosocial factors	4
Environmental stress	3
Business failure/job loss	2
Conflict with employer	2
Previous trauma	2
Age	1
Deprived childhood	1
Health	1
Hearing impairment	1
Knee	1
Menopause	1
Sex	1
Ulcer	1
Varicose veins	1
	45

Table 8 cont'd.

Accident Benefits	
Secondary gain	14
Receipt of compensation/financial support	7
Care from family/dependency needs	6
Relief from work	1
	28
Accident minor or not psychotraumatic	26
Not a true psychotraumatic neurosis	10
Out of time	10
Over-treatment or over-investigation	4
No reason given	1
	51
TOTAL*:	228

Source: Ombudsman's Records, 1977 to 1987.

*The total is greater than 122 because more than one reason was given in some cases.

accidents were felt to be operative in 28 cases, with secondary gain noted 14 times and receipt of financial benefits 7 times. Care from the family and having dependency needs met operated in 6 cases. The final reason in this category, noted once, was not having to work.

Of a miscellaneous set of reasons, the most prevalent was the Board's assertion, 26 times, that an accident was minor or not psychotraumatic. In 10 cases, it ruled that the disability was not a true psychotraumatic neurosis, and in another 10 cases that too much time had elapsed between the injury and documentation of a disability to consider entitlement. In 4 cases, overtreatment or overinvestigation was cited. Finally, in one case, no reason was given. (See Table 8.)

The Ombudsman's Findings

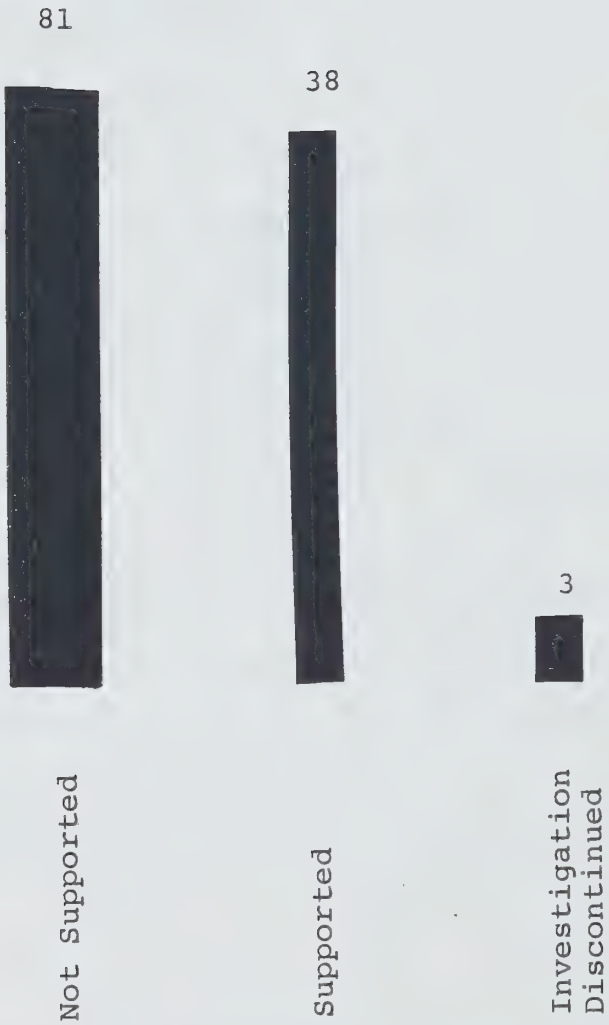
Of the 122 files reviewed, the Ombudsman was unable to support the majority (81), while in 38 of the cases there appeared to be evidence that the Appeal Board decision was unreasonable. In the remaining 3, because the complaint was withdrawn or abandoned, the investigation was discontinued before any determination was made as to whether the Board had acted reasonably. (See Table 9.)

The Ombudsman's Reasons for Supporting Complaints

In the cases receiving support from this Office, the most common reason for support was that the preponderance of medical opinion

TABLE 9

THE OMBUDSMAN'S FINDINGS



Source: Ombudsman's Records, 1977 to 1987.

favoured the worker's claim. (See Table 10.) For example, a woman who injured her back while lifting a basket of skates was described by the attending orthopaedic specialist as having a rather severe anxiety state and being badly in need of psychological and emotional support. Anxiety and depression were commented on by Board physicians examining the worker to assess the state of her back. A psychiatrist recommended counselling for the emotional problem he diagnosed as post-traumatic neurosis; a second psychiatrist diagnosed post-traumatic neurosis with reactive depression; and a neuropsychiatrist described the woman as partly to completely disabled by an accident neurosis. The worker was subsequently examined at the Board by the Committee to Assess Major Psychotraumatic Disability, which found that the vast majority of her complaints were not genuine and that considerable exaggeration was involved. In his report, the Ombudsman, unlike the Appeal Board, relied on the opinions expressed by the three psychiatrists who found a psychotraumatic disability related to a work accident, rather than on the opinion of the one who did not.

Administrative error was cited among the reasons for support as well. In one case, after injuring his back in a 40-foot fall from a ladder in 1974, a worker began experiencing advancing depression for which anti-depressant drugs were prescribed. When he asked the Board to pay for the drugs, he was turned down. Although a psychiatrist described him in 1975 and 1976 as having a 20% disabling traumatic neurotic reaction triggered by the accident, psychotraumatic entitlement was denied in 1977. Following surgery on his back in 1978, psychotraumatic entitlement was denied again in 1979 and 1981. At this Office's request

in 1982, the worker was reassessed at the Board; this time he was granted psychotraumatic entitlement in the form of a 20% pension dating from the time of his surgery. The Ombudsman, in his report, pointed out that dating the award from 1978 was incorrect, in that a psychological disability had been documented at least as early as 1975.

The manner in which the Board relies on its policy regarding pre-existing conditions was found to be sufficiently faulty at times to cause the Ombudsman to support a complaint. For example, a worker who was described by his foreman as "a good worker, reliable and honest" injured his lower back at work and had surgery the next year. He had no previous history of psychological difficulty prior to the accident but, by the following year, all the doctors who examined him, including Board physicians, deemed him to be totally disabled by his physical and psychotraumatic problems. He was awarded a pension, but the Board followed the then-current policy on pre-existing conditions and reduced the amount of the psychotraumatic component by half, on the basis that pre-existing personality circumstances contributed to his level of disability. The Ombudsman supported the worker's claim for a full pension pointing out that, when the Appeal Board reviewed the file, the current policy on pre-existing conditions was in effect and should have been applied; since there was no evidence of any pre-existing condition, there should have been no reduction in the pension.

The Ombudsman found that at times medical evidence indicated that what the Board termed a temporary disability was, instead, an

ongoing problem. For example, a worker who developed a traumatic neurotic reaction to two work injuries and subsequent surgery was described by his psychiatrist as having an unfavourable prognosis. The Board granted him a two-year lump sum award on the grounds that there was no permanent psychiatric problem. Although the family physician, an orthopaedic specialist and a second psychiatrist all wrote opinions that the worker was totally disabled, the Appeal Board concluded that the medical evidence did not show the presence of a continuing compensable psychological disability. The Ombudsman supported the complaint on the basis that the medical evidence suggested a lengthy, if not permanent, reaction to the compensable accidents rather than a problem lasting two years.

On occasion the Board appeared to have misinterpreted the medical reports on file, and hence, to have reached an unreasonable decision. For example, a worker who suffered numerous injuries was examined by two Board psychiatrists. The first psychiatrist formed the opinion that the multiple nature of the injuries, the loss of physical prowess, and the resultant loss of self-esteem created a psychological factor impairing the man's ability to function, and psychiatric entitlement should be accepted. The second psychiatrist wrote that the worker suffered from a severe and debilitating state of depression and anxiety due to the compensable accidents and subsequent loss of face when he was unable to provide for his family. Regardless, both psychiatrists were quoted by Board administrators as saying that the loss of face

TABLE 10

THE OMBUDSMAN'S REASONS FOR SUPPORTING COMPLAINTS

Preponderance of medical evidence favoured worker	18
Board failed to review the psychotraumatic component adequately	14
No evidence or incomplete evidence of a pre-existing condition	11
Disability was ongoing rather than temporary	5
Board misinterpreted medical opinion	3
Benefit of doubt was not applied	1
Five-year rule should have been waived	1
TOTAL:	53

Source: Ombudsman's Records, 1977 to 1987.

should not be considered compensable. The Ombudsman supported this case, in part, on the basis that the two psychiatrists were clear in their opinions that the worker's psychotraumatic disability was a consequence of his compensable accidents.

In another case addressed by the Ombudsman, the medical evidence for and against the worker came down to one general practitioner and one psychiatrist supporting her claim to benefits for a psychotraumatic disability, and one general practitioner and one psychiatrist finding no justification for entitlement. The Ombudsman supported the worker on the basis of the benefit of doubt policy: that is, the evidence for and against was approximately equal in weight, and the issue should have been resolved in favour of the injured worker.

Finally, the Ombudsman felt in one case that the Board's five-year rule should be waived since, even though the worker's psychological disability did not manifest itself until 10 years after his accident, repeated exacerbations produced a cumulative effect precipitating a psychotraumatic reaction and reactive depression.

SPECIFIC PROBLEM AREAS

Through review of the files a number of problems have surfaced that are worthy of comment. The most significant is the preference of the Board for its own doctors' opinions. Another is the Board's policy or procedure in matters such as: the general five-year limit; termination of benefits without review; and the determination of pre-existing conditions. Finally, phrases are commonly found in reports that place the worker's claim for entitlement in an unfavourable light, such as: "The worker received secondary gains from his disability"; The accident was not psychotraumatic"; and "The disability is not a true traumatic neurosis". These issues are addressed more fully in the following pages.

Preference for Board Doctors' Opinions

A major problem, recurring again and again, is the Board's preference for the opinion of its own physicians, to the apparent exclusion of others. At times the attending physician's opinion is rejected because it is considered to be biased in favour of the worker. In one case brought to this Office, a worker's family physician supported her claim that she suffered an anxiety reaction after a frightening incident at work, but the Board dismissed his support, saying that the doctor's advocacy interfered with his objectivity. For the Board to reject the family doctor's opinion on such a basis, with no evidence that

his judgment was faulty, is unacceptable. Recently, there has been a change in public statements by the Board; it now says that advocacy is the proper role of physicians treating injured workers. Dr. Elizabeth Kaeqi, Vice-President of Policy and Planning, went further on October 2, 1986 when she told people attending a conference sponsored by Injured Workers' Consultants that the medical staff of the Board also had a responsibility to advocate for the injured worker. Whether this attitude is adopted by Board staff remains to be seen, but its wider application would be valuable to injured workers.

The outside doctor's opinion may be rejected because there is disagreement by Board physicians as to the conclusions reached. For example, a worker's psychiatrist diagnosed psychoneurosis with tension headaches, 20% disabling. The psychiatrist concluded that the psychiatric disability was an aggravation of a pre-existing condition, the aggravation being due to a work accident; other factors were basic personality, prior trauma and secondary gain. A Board physician who had not examined the worker disagreed with the psychiatrist's conclusions, writing in part:

> I would think that the other factors enumerated by Dr. _____ are in fact, the responsible ones and the accident has really very little if any significance in the production of a trivial disorder and I would think that it is not reasonable to consider psychiatric entitlement in these circumstances.

In this case, the opinion of a psychiatrist who saw his patient over several visits received less weight from Board administrators than that of a physician who had no psychiatric specialty and who did not examine the worker at any time. Such a practice offends common sense.

The main reason for such a practice seems to be the Board's attitude that expertise resides within the Board and, therefore, it has the right to prefer the opinions of its own medical staff. A psychiatric consultant at the Board wrote in an address to colleaques:

> Some people, including our workers, are prepared to accept the opinion of outside consultants rather than the recommendation made by our expert examiners here at the Board or the consultants of this organization at the Compensation Hospital where all our doctors have been in their present consulting positions for more than a decade or so.[3]

While there is no denying that Board physicians have amassed considerable experience, this does not seem to be sufficient grounds on which to reject the opinions of outside physicians who may also possess high qualifications and wide experience, combined with extensive familiarity with the particular injured worker.

The Board has cited the Standing Committee on the Ombudsman (formerly the Select Committee) as its authority for asserting the right to prefer its own medical opinions. The Committee, in its Fifth Report in 1978, reviewed a case in which a complainant's claim to an increase in his 50% pension for asthma and bronchitis was supported by the Ombudsman after receiving an examination report from a specialist in respiratory disease. The Board's Consultant in Chest Diseases disagreed, finding

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[3] Kassay, G. The New Organic and Non-Organic Combined Rating Approach: the Medico-Legal Interpretation. Presented at the Annual Meeting, Medical Directors of WCBs of Canada. Toronto: April 26, 1985, p. 8.

that the work environment was not a significant factor in the worker's respiratory disability. The Committee supported the Board's position in this instance, writing:

> In the circumstances the Committee is of the opinion it is reasonable for the Workmen's Compensation Board to prefer the assessment of the disability made by its staff rather than an independent medical practitioner of limited experience in assessing disabilities for workmen's compensation purposes.[4]

It would appear that at least some employees at the Board have interpreted the Committee's ruling as a blanket endorsement of the Board's policy of preferring the opinions of its physicians. During a meeting of Ombudsman investigators and members of the now defunct Appeal Board, the investigators were told by one panel member that the Committee had confirmed that the opinions of Board doctors were preferred. In relying on the above quotation, however, it would appear that less attention was paid to the succeeding paragraph in the Committee's report, which read:

> The Committee should not be taken by any means that it will always disregard an opinion obtained by the Ombudsman from an expert respecting some aspect of a decision, recommendation, act or omission of a governmental organization. In this case, however, we are not dealing with medical opinions as such but judgments on the proportion of a person's disability to be covered by Workmen's Compensation benefits.[5]

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[4] Select Committee on the Ombudsman. Fifth Report, Toronto: 1978, p. 79.
[5] Select Committee, Fifth Report, p. 80.

Furthermore, the Committee addressed the issue of competing medical opinions again in its 12th Report in 1984, writing:

> It is frankly impossible not to assess the two sets of competing medical opinions and to decide which in its [the Select Committee's] opinion is the more reasonable in the circumstances.... In the meantime, until a better solution is identified, if one exists, it will continue to assess the relative merits of the medical opinions relied upon by the Ombudsman and the Board.[6]

It would seem that, in the past, the Board has selected comments out of context and attempted to apply them widely, rather than in the more limited circumstances where they are appropriate.

Determining whether a worker has a psychological disability, and what its etiology is, is a matter of medical opinion which must be weighed carefully. In one of our cases, a worker developed increasing anxiety and pain after injuring his knee in a work accident. The first attending psychiatrist diagnosed conversion hysteria triggered by the accident and a Board psychiatrist felt there was merit to this view. The Board denied psychotraumatic entitlement, however, after a second Board psychiatrist reviewed the file and concluded that there was no true psychotraumatic neurosis but, rather, that the worker's problem reflected a poor attitudinal response, an unsophisticated and primitive interpretation of the injury, and an outstanding litigation aspect. The second attending psychiatrist who examined the worker diagnosed

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[6] Select Committee on the Ombudsman. Twelfth Report, Toronto: 1984, p. 35.

conversion reaction precipitated by the accident. A third Board psychiatrist who reviewed the file was of the opinion that psychotraumatic entitlement should not be considered. The Appeal Board decided against the worker, choosing to prefer the opinions of two of its own doctors who saw no psychotraumatic disability over the opinions of three psychiatrists who did.

In another case addressed by this Office, a worker became discouraged and depressed after an eye injury, with loss of self-esteem, doubts about his future and impaired memory and concentration. Although the Board awarded the worker a 25% pension, a psychiatric consultant and the psychiatrist who had been in attendance over a number of months felt that the amount did not adequately reflect the level of disability. The Board's Committee for Assessment of Major Psychotraumatic Disability examined the worker and found his disability to be "not less than 30%." The Appeal Board quoted the Select Committee's Fifth Report to buttress its preference for the opinion of its Committee for Assessment. Ironically, in this case the reliance on the Select Committee's comments was doubly faulted, in that the findings of the Committee for Assessment implied that the pension should be increased. Ultimately, the Board accepted the Ombudsman's recommendation and increased the worker's pension to 30%.

Inadequacy of Board Physicians' Reporting

Adequacy of reporting comes into play in any discussion of reliance on Board opinions. In the past, the medical staff has frequently been guilty of writing extremely brief recommendations denying entitlement without supporting reasons. For example, a worker driving a lift truck hit a chunk of

ice and was thrown against the steering wheel with considerable force. As well as suffering physical repercussions, the worker suffered emotionally and financially. His attending psychiatrist wrote:

> From the psychiatric aspect it is my opinion that Mr. _____ is presenting with a picture of anxiety and depression ... related directly to the accident and his physical injury and pain and suffering plus the financial pressures and frustrations related to this accident and his difficulty in dealing with the WCB.... This man is becoming more depressed and irritable and unless something is done very quickly to reassess the whole situation and deal with it fairly then Mr. _____'s condition will only deteriorate from the psychiatric aspect.

Nevertheless, the Board physician reviewing the file wrote only: "Agree deny psy. ent."

While this type of response is generally attributable to the heavy workloads of Board physicians, it might also be indicative of the assumption that they need not explain how their opinions were reached. Dr. Kaegi said in her October 2, 1986 address, however, that the practice of baldly stating an opinion, without recording the reasons behind it, is no longer acceptable. Recent medical reports have been more detailed, and it is to be hoped that this will continue.

As well as providing more detail and explanation in recording the reasoning process, Board physicians should also make more effort to match the worker's level of disability with the categories of impairment formulated in its own policies. The policy guidelines provide concrete examples of behaviour, documentation of which can provide clear information in future evaluations.

Access to Information

At times, the attending physician's report is not as full as could be wished or, although written in some detail, it fails to address a point that requires the attention of an administrator. One method by which the Board might make it more likely to get the information it needs from external physicians is to distribute the written policy and procedures on psychotraumatic entitlement more widely. Copies could be sent to the psychiatrists the Board asks to evaluate a worker, and to the psychiatrists who submit reports on behalf of their patients.

Language and Cultural Differences

Frequently a problem arises when a worker is from a different cultural background or speaks a different language from a Board psychiatrist who evaluates the disability. The Board has recourse to several methods of addressing the difficulty, among them, referring the worker to an outside psychiatrist who speaks the language in question, or using professional interpreters. The most desirable is the referral of the worker to an outside psychiatrist but, unfortunately, problems arise here as well. A major concern is that there are relatively few psychiatrists familiar with other cultures or fluent in another language. And regrettably, there is no directory identifying them; knowledge of their existence and whereabouts is obtained mainly through personal contact. Given the large numbers of immigrants who make up the

population of injured workers, it would be useful for the Board to compile a list of physicians they could call on.

Another problem that can occur is that the opinion of a Board physician using an interpreter is sometimes preferred over that of the psychiatrist who speaks the worker's language. Since a good part of the psychiatric interview is spent examining fine nuances, it is obvious that the physician who understands what the worker is saying has an inherent advantage in reaching valid conclusions. For example, a worker who slipped and hurt her back was denied psychotraumatic entitlement after a Board psychiatrist stated his opinion that her psychoneurosis could not be attributed to her work accident. In addressing the complaint, this Office pointed out to the Board that her treating psychiatrist, who was knowledgable about her cultural background and spoke her mother tongue, disagreed; he attributed her psychiatric symptoms to her compensable accident. Eventually the Board accepted his medical opinion and awarded the worker a disability pension.

With the increased importance of the principle of benefit of doubt, the Board should take great care in assessing psychiatric opinions. First, the physician's academic qualifications, experience and status in the medical/psychiatric community are of paramount importance. Second, whether the physician examined the worker is significant. Third, regard must be had for whether the physician has attended the worker on more than one occasion or over an extended period of time. Fourth, the level of detail and the adequacy of reasoning as demonstrated in the

psychiatric report must be taken into account. Fifth, particular circumstances such as culture and language must be noted.

Once the assessment is made, administrators should be free to make their decisions, based on the relative merits of medical opinions, without pressure to accept an opinion simply because it arises from within the Board.

The Five-Year Limit

The Board policy that psychotraumatic disability should become manifest within five years of the accident or the last surgery has given rise to problems. First, the policy as written does not take into account the psychologically debilitating effect of recurrent episodes of disability. In one instance, a worker who injured his back in 1969 experienced and received compensation benefits for six exacerbations by 1976. In 1979, a psychiatrist was of the opinion that the worker suffered from a psychoneurotic reaction triggered by the back injury and repeated exacerbations. The worker was denied entitlement for a psychiatric disability because, in part, there was no documentation of a psychotraumatic component until 10 years after the accident. The Board reviewed the matter and granted entitlement after the Ombudsman recommended that the five-year guideline should be set aside because the crucial issue was whether the sequelae of a compensable injury, demonstrated in this case by exacerbations of back pain, may lead to

development of a psychiatric disability. The example here demonstrates that, while the five-year policy guideline can be waived, it was not waived until external review forced the Board to take a closer look at its decision. Had the policy referred to recurrences as well as to the original accident and to surgery, entitlement might have been granted earlier.

The second problem with the five-year policy is that it is sometimes incorrectly applied. For example, in 1960 a miner was struck by an ore train and pinned against a load of timber. By 1961, reports from physicians indicated that his emotional response to the accident played a major part in his ongoing disability. Although physicians continued to report a psychological problem, and a psychiatrist diagnosed traumatic neurosis with depression and anxiety in 1978, the Board denied entitlement partly because there was no "merit to debate psychiatric entitlement with such an extreme delay". It would appear that in this case the delay was in the Board's recognition of a psychotraumatic component rather than in its manifestation in the worker.

Another way in which the policy may be incorrectly applied is by shortening the time period. In one case, a worker became increasingly nervous after his truck was struck by a train in 1972. In 1975 a psychiatrist diagnosed a traumatic neurotic reaction as a consequence of the train-truck collision. Nevertheless, psychiatric entitlement was denied by the Board, in part because diagnosis of a psychological problem after a three-year delay was deemed improbable. Once again, the decision

was reversed after this Office made a recommendation which pointed out that the policy had been applied incorrectly.

Although the rule fits most cases, there are those involving recurrences where it is not appropriate. The Board should consider the role that recurrences can play in contributing to a psychotraumatic disability, and either use more discretion in applying the policy or add recurrences to the current list of accident and surgery. As well, the Board should adhere to its policy more closely where the policy is appropriate, neither ignoring reports of psychological distress close to the time of accident, nor unreasonably shortening the five-year rule.

Termination of Benefits Without Review

Awarding benefits as a lump sum for a specific term (usually two years in practice), not subject to review, appears to be based on the Board's view that a psychotraumatic disability is, in most cases, a temporary aberration, reinforcement of which could lead to psychological dependence on compensation; the corollary would be that termination of benefits provides a therapeutic effect. Reliance on this view can lead to inequity. In one instance addressed by this Office, a worker cut a finger on a piece of metal and sought first aid treatment at work. Infection and bone involvement ensued, and one year after the original injury the worker had his finger amputated. After his psychiatrist diagnosed a conversion hysteria attributable to the accident, the Board granted a 15% award for two years, payable in a lump sum, "firm and

final" without review. Although the psychological problem persisted and the psychiatrist's opinion was that the worker was not reasonably expected to improve, benefits were terminated, leaving the worker with no income. Ultimately, as a result of our recommendation, reassessment took place and a further award was granted.

Although it can be accepted that the Board was proceeding in a manner considered to be best for the worker, the absence of income is unlikely to be beneficial. As well, while some support for the Board's view can be found in the medical literature, support for the opposite view is more frequently described. Dr. V.E. Weighill, reporting on a review of the literature in 1983, looked at follow-up after settlement of claims and noted that, although there was a general impression that problems resolved on settlement, the impression was not supported by the research. Using return to work as the measure of improvement, he found that, apart from a 1961 study, results showed that few compensation patients were able to return to work and, of those who did, most never regained their pre-injury employment status. Using absence of symptoms as the measure, Weighill noted that one researcher, who did not provide data, claimed that most patients became symptom-free after settlement, while two researchers found most patients did not improve in their psychological state.[7]

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[7] Weighill, V.C. 'Compensation Neurosis': a review of the literature. J. of Psychosomatic Research. Vol. 27, No. 2, 1983, pp. 100-101.

No matter which theories find acceptance, they remain hypotheses and cannot be relied on as final truths. Given the variance in opinion among medical researchers as to the therapeutic value of closing benefits, it would seem reasonable that the Board should not arbitrarily deny entitlement past a finite date, without a review to ensure that circumstances warrant termination. One cannot always project recovery and a corresponding cessation of entitlement two years in advance; only a review at the end of the term can ensure the correctness of the original projection.

Pre-Existing Conditions

A psychotraumatic disability is viewed by the Board as an aggravation by accident of an underlying condition. Determining the nature of the underlying condition is difficult: first, psychological conditions tend to be amorphous and not easily measured or categorized; and second, data on which to base calculations are difficult to come by since it is unusual for psychological evaluation prior to the accident to comprise part of the worker's history. To address this problematic issue, the Board has included in its policy on pre-existing conditions specific reference to psychological disability, stating that a pre-existing psychological disability is to be assessed in terms of limitations shown in the work record and social integration of the worker, which have been produced by mental illness and/or defects of personality. That is, a pre-existing psychological condition is considered to be non-measurable, and its effect on the quantum of a

permanent award is determined by its effect on the worker's functioning before the accident.

Problems arise in the practical interpretation of the policy and its application or, often, its non-application. Assessment of a pre-existing psychological disability is frequently made in terms of the "defects of personality" rather than any limitations demonstrated in the work record or social integration. It is common, for example, for the Board to deny benefits on the basis of a psychotraumatic disability as a "strictly personality-related attitudinal response". Even though a worker can be characterized as insecure, passive, dependent, underassertive, fearful, excitable, histrionic, narcissistic or obsessional, adherence to the policy would necessitate investigating the worker's functioning before the work accident to decide what benefits are appropriate. In one case reviewed by this Office, for example, the Appeal Board concluded that although a worker was 70% disabled by a psychotraumatic disability, he was entitled to a lesser award because of the pre-existing vulnerable personality. The worker's file, however, contained no evidence of a psychological condition or psychiatric treatment prior to the accident: a social worker found no indication that the worker's psychological function was in any way a deterrent to his capacity to work; and the family physician reported that the worker was a well-balanced person before his injury.

Looking at the effect of the pre-existing personality defect or mental illness, rather than the defect or the illness itself, makes sense

when one considers the relevant literature as well. The medical literature on "compensation neurosis", as reported by Dr. Weighill, shows that some studies found pre-existing neurotic difficulties in the great majority of their cases; others found such predisposition in only half, and others found little evidence of prior neurotic illness.

Since there is no merit in assessing the personality out of context, the Board should examine the facts of the case and, if there is a pre-existing documented psychological disability, apply the policy as it is written. If there is no pre-existing psychological disability, the worker's personality should not be used as a justification for denying or reducing benefits.

Problematic Phrases

Among the reasons relied on by the Board to justify denying entitlement for a psychotraumatic disability are the following: "Secondary gain is prolonging the disability"; "The accident was minor or not psychotraumatic"; and "The emotional problem was not a true traumatic neurosis". While the statements may be indisputable in any given case, the reasons for their being considered as a cause to deny or reduce entitlement is not always clear. Further explication may be in order here.

Secondary Gain

Primary gain is the term given to an unconscious process whereby alleviation of anxiety is derived from the conversion of emotional concerns into demonstrably organic illnesses. Secondary gain is the catch-all term for other benefits derived as the result of an accident; also an unconscious process, it includes such items as money, attention from others, or freedom from unwelcome work. For at least two reasons, the Board's reliance on the finding of secondary gain to deny entitlement is unfortunate. The first is that secondary gain is considered to be an unconscious process, not under the conscious control of the worker. Second, while the worker may benefit from being ill, he also loses. As Dr. L. Keiser notes in The Traumatic Neurosis:

> The concept of secondary gain suggests that the patient derives an advantage from neurotic illness. This in turn often creates the feeling that the patient does not deserve the consideration usually accorded sick people, or the payment of compensation for his disability, because the illness is beneficial to him. The picture therefore becomes distorted. We must consider not only the gains but the losses.
>
> Perhaps the most significant loss suffered by the victim of traumatic neurosis is the loss of community approval. No longer is he in the mainstream of socially accepted activities. He is not earning his own living, nor is he independent. And if his illness is labelled mental he endures the stigma attached. But social isolation is not the only loss. The patient must endure the anxiety his condition creates. He must tolerate the guilt feeling that often accompanies the acceptance of compensation and endure the unrewarding role of being disabled.
>
> No patient consciously chooses the path of letting secondary gain control his behaviour and thus prolong his disability. The losses far outweigh the gains. He is as sick as if he were overwhelmed by bacteria invading his body. (Emphasis added)[8]

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[8] Keiser, L. The Traumatic Neurosis. Toronto: J.B. Lippincott, 1968, p. 55.

If secondary gain is, on one hand, unconscious and, on the other, no gain at all, it would not seem reasonable for the Board to cite it as a primary reason for denying entitlement.

The Accident Was Not Psychotraumatic

The comment, that an accident was not psychotraumatic, is justified when it is used as a descriptive phrase demonstrating that the psychotraumatic disability is not a post-traumatic stress disorder, for which one of the diagnostic criteria is that the trauma should be considered overwhelming by almost any person. It is not justified, however, in other cases where an objectively psychotraumatic event is not a diagnostic requirement, such as in conversion hysteria or anxiety neurosis. In these other cases, what is of more relevance is how the worker perceives the accident and the subsequent course of events. Dr. Keiser writes:

> It is important to note that the trauma need not appear severe to onlookers and need not cause physical injury. The key factor is: What did this trauma do to the psyche of the individual? Every person has a "breaking point" if subjected to sufficient stress. The stress necessary to create the traumatic syndrome is different for each individual.[9]

Rather than relying on the objectively non-psychotraumatic nature of an event, an attempt should be made to discern its effect.

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[9] Keiser, The Traumatic Neurosis, p. 36.

Not a True Traumatic Neurosis

An allied phrase found in the files was that a psychological problem was "not a true traumatic neurosis". Although the term was never defined in the reports, Drs. R. Culpan and C. Taylor, in a paper presented to the Congress of the Australian and New Zealand College of Psychiatrists, describe true traumatic neurosis as occurring in previously stable personalities in response to overwhelming psychic trauma or threat, clearly dating from the time of accident, and characterized by increased irritability with repetitive nightmares of the trauma. This definition brings to mind the requirements for diagnosis of a post-traumatic stress disorder, a psychotraumatic disability not in evidence in any of the cases reviewed for this paper. Given its absence, the relevance of comments such as "the accident was not psychotraumatic" or "not a true traumatic neurosis" is dubious.

While the statements referring to secondary gain, the psychotraumatic nature of the accident, and the question of whether the symptoms fit into the true traumatic neurosis category are acceptable as descriptors, the Board must take care that they do not enter the decision-making process as causes for denial of entitlement or reduction of benefits.

CONCLUSIONS AND RECOMMENDATIONS

If psychiatry were a precise science, and psychological problems neat and well-defined, then the handling of psychotraumatic complaints would become simpler and easier for everyone concerned. Since they are not precise, neat and well-defined, however, problems in adjudication exist. Although Board workers, both administrative and medical, are endeavouring to adjudicate efficiently, they are not always successful. Their lack of success may stem from two positions: first, although the Board has accepted responsibility for compensating psychological injury resulting from a work injury, a faint hint of "it's not real" would seem to linger on; second, there appears to be an unwillingness to accept that external specialists could possess expertise on psychological matters related to work injuries equivalent to that of Board physicians.

The following recommendations could help in modifying these positions:

1. The Board should accept psychological trauma as being as authentic as physical trauma and conduct its adjudication accordingly.

2. Medical opinions should be weighed carefully, taking into account the following: the physician's academic qualifications, experience and status in the medical community; whether the physician examined the worker; whether the examination occurred over time; the detail and adequacy of reasoning contained in the report; and any particular circumstances considered to be relevant.

3. Board administrators should base their decisions on the more meritorious medical opinions, whether they arise from within or outside the Board.

4. Board personnel, whether administrative or medical, should explain the reasons behind their decisions, and frame their reasons in terms of the appropriate policy.

5. A directory of psychiatrists familiar with other cultures and races or fluent in other languages should be compiled and used by the Board.

6. Copies of the Board's written policies and procedures respecting psychotraumatic entitlement should be provided to psychiatrists assessing or treating injured workers.

7. The policy on manifestation of psychotraumatic disability within five years of the original injury or surgery should be amended to include manifestation within five years of a recurrence; or, alternatively, discretion should be used in applying the present policy.

8. Benefits should not be terminated without a review to ensure that termination is warranted by the circumstances.

9. Where there might be evidence of a pre-existing psychotraumatic condition, careful reference should be had to appropriate application of the policy. That is, assessment must be made of the effects on functioning of a personality defect, not on the presence of a personality defect in the worker.

10. Phrases describing unconscious components of a psychotraumatic disability, such as secondary gain, should not be used to justify denying or limiting Board responsibility.

11. Phrases not relevant to a claim under adjudication should not be used to deny or limit entitlement.

APPENDICES

A P P E N D I X 1

THE BOARD'S HANDLING OF PSYCHOTRAUMATIC ENTITLEMENT

The Workers' Compensation Act

In the Workers' Compensation Act prior to 1985, there were general provisions that a worker would receive compensation for personal injury by accident arising out of and in the course of employment. While the old legislation did not refer specifically to psychological injury, the new legislation of 1985 does in section 45 which deals with permanent disability. Section 45(12) states:

> For the purposes of this section, "permanent disability" means any physical or functional abnormality or loss, and any psychological damage arising from such abnormality or loss, after maximal rehabilitation has been achieved. (Emphasis added)

Otherwise, all general provisions of the Act pertain equally to physical and emotional injury.

Before 1985, the benefit of doubt principle was a policy applying to all levels of Board decision-making. It read:

> In determining any claim under this Act, the decision shall be made in accordance with the real merits and justice of the case and where it is not practicable to determine an issue because the evidence for or against the issue is approximately equal in weight, the issue shall be resolved in favour of the claimant.

The policy on adjudication of claims for psychotraumatic disability stipulated that the benefit of doubt applied. In 1985 the policy was incorporated into the statute, with no change in wording, as section 3(4) of the Workers' Compensation Act.

Board Policy on Psychotraumatic Entitlement

Although the Board's policy on psychotraumatic entitlement is currently under review, there is no information yet available as to what changes are contemplated or when they will be made. The present policy states that a worker is entitled to benefits when personal injury is sustained through an accident which arises out of and occurs in the course of employment. Personal injury includes both physical and emotional disability.

Two fundamental rules are set out in the beginning of the policy:

1. the psychotraumatic disability should have become manifest within five years of the injury, or within five years of the last surgical procedure;

2. psychotraumatic disability is generally considered to be a temporary condition and only in exceptional circumstances will it be accepted as permanent.

The policy lists three sources of psychotraumatic disability:

1. brain damage;
2. emotional reaction to the accident or injury; and
3. emotional reaction to sequelae.

Brain damage can result from head injury, exposure to toxic chemicals, oxygen deprivation, or decompression sickness. For example, a painter who fell from a ladder, and was knocked unconscious when struck on the head by a falling paint can, was diagnosed as having a cerebral concussion. The Board paid temporary total disability benefits and, when

he exhibited ongoing symptoms of a post-concussive syndrome, granted him a 10% permanent disability award.

Emotional reaction can be caused by accident, injury, severe physical disability or the treatment process. For example, a worker caught her hand in a machine and amputated the first and second fingers. Two months later her doctor advised the Board that the major problem was a psychological one: she was becoming a social invalid, afraid to go out in public because of the physical deformity. The Board accepted responsibility for psychological difficulties and paid for psychotherapy.

Emotional reaction can also be caused by the sequelae of the accident: that is, by extended disablement and by non-medical, socio-economic factors, the majority of which flow from the compensable injury. For example, over a period of 15 years, a worker had six accidents in which he injured his back, neck and foot to an extent that he was awarded a 46% pension for physical disability. When he exhibited psychological difficulties, a Board psychiatrist examined him and reached the conclusion that multiple injuries and consequent psychological problems impaired the worker's ability to function. He was eventually granted a 100% permanent disability award to compensate for the combination of psychological and physical problems.

Board policy stipulates that, where a history of prior psychiatric condition has been demonstrated, compensation may be extended to the worker on the basis of aggravation. If a psychiatric disability

unrelated to the accident exists, and its treatment will enhance recovery of the worker's physical disability, the Board may pay for such treatment.

Board Procedures in Psychotraumatic Entitlement

Certain procedures have been developed based on Board policies:

1. The adjudicator working on a claim is warned that early recognition is advisable, and suggestions as to possible indicators are made.

2. Diagnostic terms and impressions such as "conversion reaction" or "depressive features" appearing in medical reports should alert the adjudicator to the possibility of a psychological factor to the injury.

3. A history of prior psychiatric treatment or of current prescription of tranquilizers, antidepressants, or potent analgesics may also indicate a problem.

4. The adjudicator is directed to watch out for prolonged recovery from the physical injury and has reference to a chart which provides guidelines as to reasonable recovery time. For example, a fracture of the femur could be expected to disable the worker for six to nine months, a simple fracture of the finger for three weeks. Disability exceeding the expected time might indicate the presence of a psychological problem.

If the adjudicator recognizes that a claim may involve psychotraumatic disability, the file is directed to a Board physician who determines whether psychotraumatic entitlement should be pursued. If the doctor is of the opinion that psychotraumatic assessment is not warranted, the medical reasons are to be documented, and the file returned to the adjudicator. If the doctor is of the opinion that psychotraumatic features are significant, the file is to be sent to a senior physician for consideration of admission to the Psychiatric Social Evaluation Module (PSEM) if less than two years from the date of

accident, or a referral is to be made to a psychiatrist at the Board's Hospital and Rehabilitation Centre on an out-patient basis if between two and five years from the date of accident. Not all workers with a psychotraumatic disability, however, are assessed by Board psychiatrists; many are referred to an independent psychiatrist by their own physician.

The PSEM is a special clinic at the Downsview Hospital and Rehabilitation Centre which may evaluate and treat a worker with a psychotraumatic disability. Prior to admitting the worker to the clinic, a social worker pays a home visit to take a detailed history and to evaluate the worker's baseline level of functioning, and relationship with the family and community. After admission, the worker is assessed by the other members of the team: psychologist, psychiatrist, rehabilitation counsellor, occupational therapist, remedial gymnast, and orthopaedist. Following assessment, the team and a senior Claims representative meet in conference to decide what entitlement and benefits are appropriate.

When the worker is assessed by a Board or independent psychiatrist, the adjudicator sends the psychiatric report to a Board medical adviser and to an administrative supervisor. The medical adviser gives an opinion as to compatibility of the psychotraumatic disability with the accident and refers the file to the psychiatric consultant; the administrative supervisor evaluates the overall nature of the file.

The psychiatric consultant makes arrangements for further assessment if necessary, or "establishes the percentage and term of the award", in keeping with Board guidelines.

In complex cases, a Committee for Assessment of Major Psychotraumatic Disability (sometimes referred to as the PDRC), consisting of a senior staff person from Claims, a surgical consultant, a permanent disability medical consultant, and a psychiatric consultant, may be struck to assess the worker. Before the worker is seen, a social worker makes a home visit. At the Board's offices, the surgical consultant and the permanent disability medical consultant examine the worker to assess the physical condition, and the psychiatric consultant interviews the worker to assess the psychological condition. After the medical examinations are completed, the senior staff person interviews the worker. Finally, the team members meet to decide the worker's level of disability, and to recommend whether psychiatric entitlement is in order.

Once the psychiatric consultant or the PSEM team has determined that a worker has entitlement for a psychotraumatic disability, benefits may be administered in one of four ways:

1. temporarily;
2. as a lump sum award for a specific term, not subject to review;
3. as a provisional pension for a specific term with review; or,
4. as a permanent pension.

If it is felt that a pension for a psychotraumatic disability may be in order, pension assessment is not done until after any physical disability is rated, except when the total rating is done at one assessment by the PDRC.

Board Statistics

Board statistics regarding psychotraumatic entitlement must be approached with some caution. Records of initial claims including a psychotraumatic disability were not kept until 1984 when 43 such claims were tallied; and in 1985 there were 38. These figures do not reflect the extent of the problem because psychological disabilities tend to be demonstrated some time after the original accident rather than immediately.

A clearer picture can be obtained by looking at the number of claims reviewed by psychiatric consultants, ranging from 524 to 751, with an average of 629 per year, between 1980 and 1985. If we were to take 1984 as a representative year, we would see that the Board accepted 368,502 claims in total: of that number, 751 claims were reviewed by psychiatric consultants; 217 psychiatric examinations were done; and 60 interviews were conducted by the Committee for Assessment of Major Psychotraumatic Disability. (See Table 11.)

Of the 217 workers who were examined by psychiatric consultants in 1984, 180 received some sort of award. Conversely, of 328 workers who were assessed at the Psychological Social Evaluation Module in 1984, 229 were found to have no psychiatric disability and, therefore, no

TABLE 11

ACCEPTED CLAIMS AND CLAIMS WITH PSYCHOTRAUMATIC ENTITLEMENT COMPONENT

WORKERS' COMPENSATION BOARD

1980 - 1985

YEAR	ACCEPTED CLAIMS	CLAIMS INITIALLY INDICATING PSYCHO-TRAUMATIC COMPONENT	REVIEWS BY PSYCHIATRIC CONSULTANTS	EXAMINATIONS BY PSYCHIATRIC CONSULTANTS	EXAMINATIONS BY THE COMMITTEE FOR ASSESSMENT OF MAJOR PSYCHOTRAUMATIC DISABILITY
1980	416,342		602		
1981	389,462		524		
1982	333,905		601		
1983	327,775		567		
1984	368,502	43	751	217	60
1985	402,860	38	729	417	75

Source: WCB, Acting Secretary of the Board, 1986.

entitlement was extended. Added to this number were the 47 workers who were found to have a psychiatric problem that was non-compensable. That is, entitlement was denied in 276 of the 328 evaluations done by the PSEM in 1984. (See Tables 12 and 13.)

Workers, whose average stay in the PSEM in 1984 was 19.1 days, were deemed to be able to return to regular work in 226 cases, and to modified work in 60. In only 22 cases was it felt that further treatment or investigation was warranted. (See Table 14.)

Pre-Existing Conditions

Throughout the procedure of adjudicating psychotraumatic entitlement, other policies relating generally to any injury or particularly to an emotional injury come into play. These policies include the one on pre-existing conditions.

If a worker has been able to work with a pre-existing condition and then suffers a work injury, compensation benefits are awarded on the basis of aggravation if the underlying condition increases the degree of disability subsequent to the accident, the duration of treatment and recovery, or the degree of permanent impairment.

If the worker's disability is permanent, the underlying condition is assessed to determine what its effect on the pension will be. If the condition produced a minor pre-accident disability, the full pension is awarded; if moderate, 75%; and if major, 50%. For example, if

TABLE 12

ENTITLEMENT OUTCOME OF EXAMINATIONS BY PSYCHIATRIC CONSULTANTS

WORKERS' COMPENSATION BOARD

1984 - 1985

YEAR	EXAMINATIONS BY PSYCHIATRIC CONSULTANTS	NO ENTITLEMENT	PROVISIONAL AWARDS	PERMANENT AWARDS	COMBINED AWARDS	TOTAL AWARDS
1984	217	37	98	75	7	180
1985	417	75	138	192	12	342

Source: WCB, Acting Secretary of the Board, 1986.

TABLE 13

PSYCHOLOGICAL SOCIAL EVALUATION MODULE (PSEM)

DETERMINATION OF PSYCHIATRIC DISABILITY

1983 - 1985

YEAR	PSEM ADMISSIONS	COMPENSABLE DISABILITY	NON-COMPENSABLE DISABILITY	PARTLY COMPENSABLE DISABILITY	ASSESSMENT INCOMPLETE	NO PSYCHIATRIC DISABILITY
1983	349	42	80	13	13	201
1984	328	48	47	2	2	229
1985	363	51	2	0	0	310

Source: WCB, PSEM Annual Report, January 1st, 1985 to December 31st, 1985.

TABLE 14

PSYCHOLOGICAL SOCIAL EVALUATION MODULE (PSEM)

AVERAGE STAY AND DISPOSITION ON DISCHARGE

1983 - 1985

YEAR	PSEM ADMISSIONS	AVERAGE DURATION OF STAY IN DAYS	RETURNED TO REGULAR WORK	RETURNED TO MODIFIED WORK	FURTHER TREATMENT &/OR INVESTIGATION	OTHER
1983	349	19.3	184	124	26	15
1984	328	19.1	226	60	22	20
1985	363	18.9	180	56	37	90

Source: WCB, Acting Secretary of the Board, 1986.

a worker's permanent disability was rated at 40%, and the pre-existing disability was assessed as moderate, the pension would be 30% (75% of 40%).

A pre-existing psychological condition is assessed "in terms of the limitations shown in the work record and social integration of the worker that had been produced by mental illness and/or defects of personality". How one makes the assessment is not spelled out further.

Second Injury and Enhancement Fund Relief

The aim of the Second Injury and Enhancement Fund (SIEF) is to encourage employers to hire disabled workers by relieving all or part of the employer's compensation and medical aid costs when an accident is caused or contributed to by a prior disability, or when the worker's disability is enhanced by a pre-existing condition. The medical significance of the underlying condition and the severity of the accident are assessed in determining what percentage of relief the employer is to relieve.

In assessing the medical significance of a psychological condition, the policy indicates that it is not necessary to demonstrate pre-existing psychological impairment. However, the possibility of prior traumatic life experiences can be considered as evidence of vulnerability that would justify granting relief to the employer.

Evaluation and Rating of Impairment Due to Psychoneurosis Following Industrial Injuries

The policy guidelines state that evaluation of impairment due to post-traumatic neurosis should be made in accordance with six disorders: anxiety neurosis with depressive features; anxiety neurosis with psychosomatic manifestations (also referred to as psychological factors affecting physical condition); conversion (hysterical) neurosis; obsessive compulsive neurosis; anxiety neurosis with phobic features; and anxiety neurosis with hypochondriasis. Board physicians have stated that disorders included in the third edition of the Diagnostic and Statistical Manual of Mental Disorders, more commonly referred to as DSM-III, will also be considered. It should be noted that psychogenic pain disorder, included in the DSM-III, has not in the past been accepted as compensable by the Board. The issue of enigmatic chronic pain and pain magnification, however, was considered by the Workers' Compensation Appeals Tribunal in its Pension Assessment Appeals Leading Case in 1986. In decision number 915, the Tribunal concluded on the basis of the evidence, including the DSM-III, that psychogenic pain disorders include chronic pain and pain magnification and are deserving of entitlement when they constitute disabling conditions resulting from a compensable injury.

Four levels of impairment of the total person due to post-traumatic neurosis are categorized: minor, moderate, major, and severe. In the minor impairment category, which allows 10%, the outstanding finding is persistent pain which has restricted the worker's function to a limited degree.

In the moderate impairment category, allowing 15% to 25%, symptoms include persistent pain, emotional withdrawal, loss of appetite, insomnia, chronic fatigue, low noise tolerance, low activity level, and interference with social functioning.

In the major impairment category, allowing 30% to 50%, symptoms include severe anxiety, depressive episodes, withdrawal from the family and society, severe noise intolerance, significantly diminished stress tolerance, and phobia or conversion reaction with bizarre behaviour. Activities are restricted to the point where the worker is frequently homebound or roombound.

In the severe impairment category, allowing 60% to 80%, symptoms include withdrawal, forgetfulness, inability to concentrate, neglect of personal hygiene, loss of interest in the environment, extreme irritability, significant changes of mood, and uncontrolled outbursts of temper. The worker is usually homebound or roombound.

When a worker with a psychological problem comes to the Board, the policies and procedures reproduced in appendices 3, 4, 5, 7 and 8, and outlined here, are applied in answering four basic questions about psychotraumatic entitlement:

1. Does the worker have a psychiatric problem?
2. Is it disabling?
3. Is the disability related to a work accident?
4. What benefits are appropriate?

When the worker is dissatisfied with the Board's answers, the next step is recourse to the appeals system.

A P P E N D I X 2

THE APPEALS SYSTEM AND THE OMBUDSMAN

The Appeals System Prior to 1985

Before 1985, a decision to disallow a claim brought to the Workers' Compensation Board was automatically reviewed by staff in the Claims Review Branch before being transmitted to the worker and the employer. If either of the two parties was dissatisfied, an appeal could be requested. The request would be considered by an Appeals Adjudicator who could follow one of three courses: make a decision based on the information available in the file; convene an Appeals Adjudicator hearing; or refer the matter to an Appeal Board composed of three Commissioners of the Board, the final decision-making body. If the Appeals Adjudicator chose either of the first two courses and the worker or employer objected to the subsequent decision, appeal could be made to the Appeal Board.

To prepare for a hearing, the appellant was entitled to obtain, without cost, a copy of the Board's claim file. Workers had access to Worker's Advisers, employees of the Board whose job it was to assist, without cost, in the preparation and presentation of appeals. All parties to the appeal testified under oath and were entitled to present their views, introduce evidence, and call and question witnesses; however, they could not cross-examine. If the Appeal Board panel felt that it did not have sufficient evidence on which to base a decision, it might stay its decision in order for Board staff to gather whatever further information was necessary. For example, if a worker testified

that a consultation with a psychiatrist had taken place but the report was not yet available, the Appeal Board would likely want to consider the new evidence before making its decision. If the panel had sufficient evidence, it would meet after the hearing to make its decision. Although an Appeal Board was the final stage of decision-making, the Board retained the right to reconsider any decision if there was new evidence, or if there had been a procedural error.

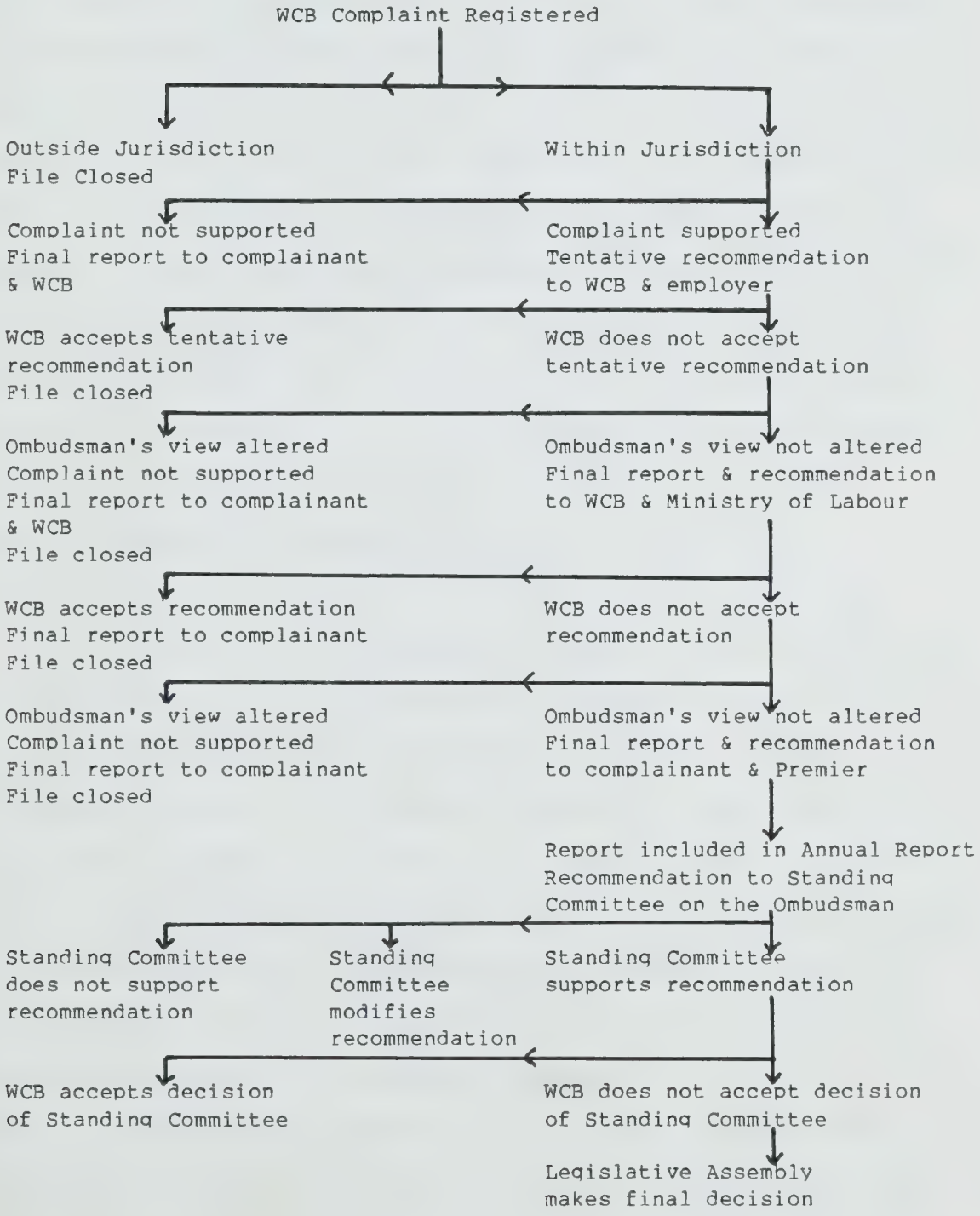
The Ombudsman's Relationship

Section 15 of the Ombudsman Act empowers the Ombudsman to investigate any decision, recommendation or act of a governmental organization such as the Workers' Compensation Board, after all rights of appeal have been exhausted. Since the Appeal Board was the final level of appeal at the Workers' Compensation Board, most of this Office's investigation of decisions, recommendations or acts by the Board involved Appeal Board decisions.

As with investigations of complaints against other governmental organizations, the first step was to notify the Board of our intent to investigate. After the Board's response was received, an investigator reviewed and summarized the Board file, discussed the matter with the person who registered the complaint, sought out further evidence if necessary, and presented the facts and arguments to the Ombudsman. If the Ombudsman reached a tentative opinion that a complainant's objection to a decision could be supported, letters outlining the basis for the Ombudsman's view were sent to the Board and the accident employer asking

FIGURE 1

DECISION TREE OF WCB COMPLAINTS REGISTERED WITH THE OFFICE OF THE OMBUDSMAN



for responses. If the responses did not persuade the Ombudsman to change his tentative opinion, a final report with his formal conclusion(s) and recommendation(s) would be sent to the Board and the Ministry of Labour. Once the Board's response, either positive or negative, was received, the report would go to the complainant. If the Board declined to implement the recommendation(s), and its reasons at this stage did not persuade the Ombudsman to change his view, the final report would go to the Premier of Ontario and, finally, to the Standing Committee on the Ombudsman. A summary would be included in the Ombudsman's Annual Report as well. If agreement between the Board and the Ombudsman could not be reached before the Standing Committee held its annual fall meeting, the case would be presented to the Committee for a decision as to whether the Board should implement the recommendation(s). If the Committee directed the Board to do so and the Board still declined, the case might go before the Legislative Assembly for debate by the House.

If we were to take 1984/85 as a typical year, we would see that this Office dealt with 515 jurisdictional complaints against the Board, just under one-tenth of the 5,366 jurisdictional complaints dealt with by the Ombudsman that year. (It should be noted that a worker could have more than one jurisdictional complaint at a time.) In just over one-half (277), the Ombudsman found the complaint to be unsubstantiated; 179 files were closed without making a determination as to whether the Board had acted unreasonably, because the complaints were withdrawn, abandoned or resolved independently; the Ombudsman supported or assisted 59 complaints; and he made recommendations in 30 cases. Nine of these were accepted by the Board; 21 were denied and ultimately sent to the Standing

Committee. Further negotiation took place and, by the time the Annual Report was published, the number of recommendations denied had dropped to 11. By September, all but 2 cases involving recommendations had been resolved and, following review by the Committee, were then supported and accepted by the Board. In 1985/86 all cases in which the recommendation had been denied were resolved before the Standing Committee met. With reference to psychotraumatic entitlement claims in 1984/85, the Ombudsman supported or assisted 8 of 28 complaints but was unable to support 16. Three files were closed without a recommendation made when the investigation showed that an adequate alternative remedy was available to the complainant. One file was closed when the Ombudsman was unable to contact the complainant after the complaint was registered. (See Tables 15 and 16.)

In the past, there has been some friction between the Board and the Office of the Ombudsman. Since the appointment in 1985 of Dr. R. Elgie as Chairman of the Board, a better understanding has emerged and, although problems still exist, a more positive working relationship now prevails. This is somewhat ironic in that, with the changes in the Workers' Compensation Act in 1985, the final level of appeal now lies outside the Board with the Workers' Compensation Appeals Tribunal. Accordingly, complaints to the Ombudsman against the Workers' Compensation Board have declined from about ten per cent of all jurisdictional complaints prior to 1985 to considerably under one per cent.

TABLE 15

DISPOSITION OF JURISDICTIONAL WCB COMPLAINTS REVIEWED BY

THE OFFICE OF THE OMBUDSMAN

October 1977 - March 1986

YEAR	WCB COMPLAINTS	SUPPORTED OR ASSISTED	NOT SUPPORTED	OTHER
Oct. 77/ Mar. 78	185	39	96	50
1978/79	276	81	121	74
1979/80	264	82	131	51
1980/81	726	251	413	62
1981/82	522	46	375	101
1982/83	627	40	382	205
1983/84	754	51	288	415
1984/85	565	59	277	229
1985/86	419	35	217	167
TOTAL:	4,338	684	2,300	1,354

Source: Ombudsman Records, 1977 to 1987.

TABLE 16

DISPOSITION OF JURISDICTIONAL PSYCHOTRAUMATIC ENTITLEMENT (PE) COMPLAINTS

REVIEWED BY THE OFFICE OF THE OMBUDSMAN

October 1977 - March 1986

YEAR	PE COMPLAINTS	SUPPORTED OR ASSISTED	NOT SUPPORTED	OTHER
Oct. 77/ Mar. 78	6	3	2	1
1978/79	9	6	3	0
1979/80	14	4	10	0
1980/81	19	4	14	1
1981/82	23	3	18	2
1982/83	36	1	20	15
1983/84	25	9	13	3
1984/85	28	8	16	4
1985/86	15	7	7	1
TOTAL:	175	45	103	27

Source: Ombudsman Records, 1977 to 1987.

The Appeals System After 1985

In the new appeals system currently operating within the Board, the Review Services Division is charged with investigating objections to decisions. A Decision Review Specialist changes or confirms decisions and, if confirmed, the decisions are referred to a Hearings Officer, similar to the former Appeals Adjudicator, and now the final stage of internal review.

Replacing the Appeal Board is the Workers' Compensation Appeals Tribunal, an independent external body under the aegis of the Ministry of Labour, which has now been in operation for almost three years. Although the advent of the Appeals Tribunal places the Ombudsman at a step removed from the Board, nevertheless, the experience gleaned by this Office over the years may still prove helpful to those workers who experience psychological difficulty after an accident at work, and to those who find themselves involved in the ensuing problems.

A P P E N D I X 3

Directive 22. THE ADJUDICATION OF CLAIMS FOR PSYCHOTRAUMATIC DISABILITY

A worker is entitled to benefits when personal injury is sustained through an accident which arises out of and occurs in the course of employment. "Injury" includes both physical and emotional disability.

1. GENERAL RULE

Where it is evident that a diagnosis of a psychotraumatic disability is attributable to a compensable injury or its sequelae, entitlement shall be granted providing that the psychotraumatic disability became manifest within five years of the injury, or within five years of the last surgical procedure.

Psychotraumatic disability is considered to be a temporary condition. Only in exceptional circumstances will this type of disability be accepted as a permanent condition.

2. PSYCHOTRAUMATIC DISABILITY ENTITLEMENT

Entitlement for psychotraumatic disability may be established when the following circumstances exist or develop:

2.1 Organic brain syndrome secondary to: traumatic head injury, toxic chemicals including gases, hypoxic conditions or conditions related to decompression sickness.

2.2 As an indirect result of a physical injury.

2.2.1 Emotional reaction to the accident or injury.

2.2.2 Severe physical disability.

2.2.3 Reaction to the treatment process.

2.3 The psychotraumatic disability is shown to be related to extended disablement and to non-medical, socio-economic factors, the majority of which can be directly and clearly related to the compensable injury.

3. OTHER FACTORS

The following relevant points should be evaluated in assessing the extent of psychotraumatic disability entitlement:

3.1 Prior History - In all cases where history of a prior psychiatric condition has been shown to exist, the question of allowance on an aggravation basis shall be considered, having regard for the emotional effect of the occupational occurrence and its sequelae.

3.2 Unrelated Psychiatric Disability - In some cases, psychiatric disability may become apparent in an otherwise uneventful case, and enquiry establishes its origins to other factors (such as family crisis), having no relationship whatsoever to the accident. On medical advice and under the provisions of Section 23 of the Act, allowance may be made for concurrent treatment. The psychiatric treatment will be in order during the period of active treatment for the physical disability, so long as such treatment enhances the recovery of the physical disability, in the opinion of the Board.

4. SECOND INJURY AND ENHANCEMENT FUND RELIEF

In claims for psychotraumatic disability, the Board approved policy regarding the aggravation of pre-existing conditions and application of the Second Injury and Enhancement Fund shall be applied.

5. BENEFIT OF DOUBT

Claims which do not meet the above criteria shall be individually judged on their own merits having regard for the evidence submitted. The benefit of doubt applies.

February 9, 1982
Bd. M.4951 #11

Source: Workers' Compensation Board, Board Policies & Administrative Directives.

A P P E N D I X 4

Section
PSYCHOLOGICAL DISABILITY

Subject
PSYCHOTRAUMATIC DISABILITY

REFERENCES: Sections 1(1)(a)(iii), 23, 40 and 71(3) of the Act. Board Policies And Divisional Administrative Guidelines, Claims Services Division - Pages 207 to 208.

POLICY: Where it is evident that a diagnosis of a psychotraumatic disability is attributable to a compensable injury or its sequelae, entitlement shall be granted, providing the psychotraumatic disability became manifest within five years of the injury, or within five years of the last surgical procedure.

Psychotraumatic disability is considered to be a temporary condition. Only in exceptional circumstances will this type of disability be accepted as a permanent condition.

GENERAL INFORMATION:

1. Psychotraumatic disability may result from:

   - organic brain damage following traumatic head injury, exposure to toxic chemicals including gases, hypoxic conditions or conditions related to decompression sickness,
   - emotional reaction to the accident, injury or severe physical disability, or
   - reaction to the treatment process.

2. The psychotraumatic disability may also be related to extended disablement and to non-medical, socio-economic factors, the majority of which can be directly related to the compensable injury.

3. Medical management of the organic disability is essential in early stages and will aid in recognition, diagnosis and treatment of psychotraumatic disabilities.

4. Consider cases for early admission to the Psychological and Social Evaluation Module (PSEM) as early as possible. (See Psychological Social Evaluation Module (PSEM), Document Number 33-21-02.)

GENERAL INFORMATION: (cont.)

5. When psychological condition results from a severe head injury, entitlement will be determined by the Neurological Clinic at DRC. (See PERMANENT DISABILITY: Rating of Serious Head Injuries, Document Number 33-20-06).

EARLY RECOGNITION:

6. The Claims Adjudicator and the Section Medical Adviser are responsible for recognizing cases where a psychotraumatic condition develops. Mild depression or anxiety related to the accident and/or its sequelae (i.e. startle reaction) may not indicate an assessment referral.

7. The Adjudicator reviews all reports such as progress reports (Forms 41 and 26) correspondence, Vocational Rehabilitation reports (Forms 589 and 1754) and all medical documentation watching for:

a. diagnostic terms such as:

- Post-Traumatic Neurosis
- Conversion Reaction
- Personality Disorders
- Post-Traumatic Psychotic Reactions

b. diagnostic impressions such as Anxiety Neurosis with:

- Depressive Features
- Phobic Features
- Hypochondriasis
- Psychosomatic Manifestations

c. personality-related emotional reactions, i.e. the worker's attitudinal response to the accident, extensive diagnostic investigations and reaction to the treatment process,

d. "functional overlay", i.e. exaggeration and magnification to the residual physical impairment,

Note: Consider this term cautiously as it is not a well accepted diagnostic entity,

e. prior problems, i.e. a history of pre-existing psychiatric conditions including documentation of previous hospitalization(s) and/or treatment,

GENERAL INFORMATION: (cont.)

f. prolonged recovery in relation to the physical injury,

g. prescribed drug therapy, such as:

- Anxiety-controlling tranquillizers, e.g. Diazepam (Valium or Vivol), Librium, and Solium;
- Anti-depressants, e.g. Imipramine, Etrafons and Elavil (Amitryptiline);
- Pain-controlling agents, e.g. Tylenol #3, 282's, 292's, Demerol and Percodan;
- Psychotropic drugs, e.g. Chlorpromazine, Mellaril and Stelazine.

The above suggests the existence of an emotional response and requires clarification.

8. Claims which do not meet the criteria are individually judged on their own merits, having regard for the evidence submitted.

9. Claims should be reviewed for the purpose of Second Injury and Enhancement Fund application (see SECOND INJURY AND ENHANCEMENT FUND: Permanent Disability, Document Number 33-28-03).

PROCEDURES: EARLY RECOGNITION:

1. When a psychotraumatic condition is recognized, the Adjudicator directs a memo to the Section Medical Adviser through the Team Co-ordinator, outlining:

- history of accident,
- initial diagnosis,
- treatment process,
- description of the current issue, and

requests direction on the medical administration of the claim.

Note: Where diagnosis of "stress" appears in the initial adjudication of a claim, refer the file directly to the Senior Section Medical Adviser.

2. The Section Medical Adviser determines whether psychotraumatic entitlement should be pursued or not.

PROCEDURES: (cont.)

3. Where psychotraumatic assessment is not indicated, the Medical Adviser documents the medical reasons, recommends specific treatment management and returns the file to the Adjudicator.

4. Where psychotraumatic features are significant, under 2 years from the date of injury, the Section Medical Adviser refers files to the Senior Section Medical Adviser for consideration of admission to PSEM or referral to a psychiatrist at DRC on an out-patient basis.

   In cases where the psychotraumatic features develop between 2 and 5 years from the date of accident, the medical management requires a senior medical opinion for referral to DRC on an out-patient basis.

PSYCHIATRIC EVALUATION ON FILE:

5. After discharge from PSEM the Adjudicator administers the recommendation(s) of the PSEM Conference (see Psychological Social Evaluation Module (PSEM), Document Number 33-21-02.)

6. Where the worker's DRC evaluation is on an out-patient basis, the psychiatric report is forwarded to the Senior Section Medical Adviser for opinion and referral to the Psychiatric Consultant.

7. On receipt of an external psychiatric report, the Adjudicator reviews the file, attaches all relevant claims and directs a memo to the Section Medical Adviser with the following information:

   Entitlement

   Accident date, nature of injury, brief outline of treatment including DRC admissions, nature and dates of surgery. Was the period of recovery unduly prolonged, noting the nature of the injuries and treatment? When will the claim be ready for permanent disability rating of physical injuries?

   Psychiatric Profile

   - When the psychotraumatic condition first mentioned in a medical report.
   - The time between the accident, treatment and the onset of the psychotraumatic disability.
   - Whether medically the psychotraumatic disability is described as being partially or fully related to the accident.
   - Is the worker disabled from work due to the psychotraumatic disability.

PROCEDURES: (cont.)

- Whether Vocational Rehabilitation Branch is actively assisting the worker.
- Any history of prior psychotraumatic illnes and details.
- Recommended treatment of current psychotraumatic disability.

Recommendations

- Diagnosis, opinions and conclusions from the psychiatric report.
- Request medical opinion regarding:
  - existence of psychotraumatic condition and
  - compatibility to the history of accident
- Percentage applicable for the Second Injury and Enhancement Fund.
- Entitlement to benefits under Section 40(1) or Section 40(2)(b), having regard for the physical disability.

  Note: Where intensive psychotherapy recommended Section 23 may require consideration. (See: TREATMENT CONTROL: Section 23, Document Number 33-32-11).

MEDICAL MANAGEMENT:

8. The Senior Section Medical Adviser will comment on:

   - compatibility of the psychotraumatic disability to the history of accident,
   - whether or not treatment is in order, and

   refer the claim to the Psychiatric Consultant.

9. The Psychiatric Consultant:

   - reviews the claim concerning treatment, and
   - makes arrangements for further assessment where necessary, or
   - establishes the percentage and term of the award, in keeping with the Guidelines for the Evaluation and Rating of Impairment Due to Psychoneurosis.

10. Once entitlement is determined, the Adjudicator carries out the action outlined and flags the Entitlement Section of the claims jacket. (See FORMS AND JACKET: Claims Jacket, Document Number 33-11-03).

PROCEDURES: (cont.)

PAYMENT OF CLAIMS:

11. In cases where minor psychotraumatic entitlement is in order but there is no permanent organic disability the Adjudicator:

    . mark-ups Temporary Partial (T.P.) Lump Sum award (on percentage basis) on Payment Authorization Sheet, Form 0712 and "Final". See example mark-up,
    . advises worker, employer and representative of the entitlement.

    Note: All lump sum awards are deducted from any future benefits and the worker is so informed.

12. Where psychotraumatic entitlement is granted while there is an ongoing organic disability, temporary benefits continue in accordance with the level of disability.

13. The permanent disability assessment is conducted within usual time frames and the psychotraumatic award is held until after the clinical disability is confirmed. See PERMANENT DISABILITY: Basic Concepts, Document Number 33-20-01 and PSYCHOLOGICAL DISABILITY: Rating of Claims for Psychotraumatic Disability, Document Number 33-21-03.

UNRELATED PSYCHOTRAUMATIC DISABILITY:

14. Where the psychiatric disability has no relationship to the accident or its sequelae and there is no permanent physical disability, inform the worker, employer and representatives of benefit closure and flag the Warning Section of the claim jacket.

15. In cases where total or partial physical disability exists, continue benefits acording to the extent of the physical disability under Section 40(1) or Section 40(2)(b).

OBJECTIONS:

16. Where the worker, employer or representative objects to the decision concerning a psychotraumatic disability see ADJUDICATION: Restrictive Decisions, Document Number 33-02-30.

Source: Workers' Compensation Board, Claims Adjudication Branch Procedures Manual.

A P P E N D I X 5

Directive 23. EVALUATION AND RATING OF IMPAIRMENT DUE TO PSYCHONEUROSIS FOLLOWING INDUSTRIAL INJURIES

The impairment due to post-traumatic neurosis is evaluated in line with the following six clinical entities, one or more of which may be present:

1. Anxiety Neurosis with Depressive Features

2. Anxiety Neurosis with Psychosomatic Manifestations (Psychological factors affecting physical condition)*(DSM III)

3. Conversion (Hysterical) Neurosis

4. Obsessive Compulsive Neurosis

5. Anxiety Neurosis with Phobic Features

6. Anxiety Neurosis with Hypochondriasis.

Consideration will be given to the predominant symptoms but, clinically, it is always a mixed state including not only the accident related anxiety depressive reaction but, also, the non-traumatic neurotic syndrome. Added to these are the superimposed personality tendencies which are important preconditioning factors in every accident.

These guidelines shall apply to the assessment of psychological lump sum awards and permanent disability awards. (Lump sum awards do not apply to Categories III and IV).

The guidelines for claims adjudication involving pre-existing conditions and application of the Second Injury and Enhancement Fund will apply.

*Diagnostic & Statistical Manual, American Psychiatric Association.

CATEGORY I - Minor Impairment Of The Total Person

(10%):

In this category the injured worker's daily activity is slightly limited and no apparent difficulties are reported in personal adjustment. There is also some loss in personal or social efficiency and the secondary psychogenic aggravations are caused by the emotional impact of the accident. The outstanding symptom is the worker's statement of persistent pain which has restricted to a limited degree, the functioning ability of the injured person.

A mild anxiety reaction shall be apparent. The display of symptoms indicate a form of restlessness, some degree of subjective uneasy

feelings and tension caused by anxiety. There shall be some resultant subjective limitations in functions.

The disability, from the psychiatric point of view, is not expected to be permanent.

CATEGORY II - Moderate Impairment Of The Total Person

(15% To 25%):

In this category, the worker is still capable of looking after personal needs in the home environment but, at times insidiously, confidence will diminish and the worker will be more dependent on the members of the family in all extramural activities. The worker demonstrates a moderate, at times episodical, anxiety state, agitation with "traumatophobia", nurturing strong passive dependency tendencies.

The emotional state may be compounded by objective physical discomfort with persistent pain, signs of emotional withdrawal and depressive features, loss of appetite, insomnia, chronic fatique, low noise tolerance, mild psychomotor retardation and definite limitations in social and personal adjustment within the family. At this stage, there is a clear indication of some psychological regression and signs of atrophy will surface insidiously.

CATEGORY III - Major Impairment Of The Total Person

(30% To 50%)

In this category the worker displays a severe anxiety state, definite deterioration in family adjustment, incipient breakdown of social integration, and longer episodes of depression (depressive neurosis). The worker tends to withdraw from the family, develops severe noise intolerance and a significant diminished stress tolerance. A phobic pattern or conversion reaction will surface with some bizarre behaviour, tendencies to avoid anxiety-creating situations, with everyday activities restricted to such an extent that the worker may be homebound or even roombound at frequent intervals.

CATEGORY IV - Severe Impairment Of The Total Person

(60% To 80%)

In this category, the worker displays a clear indication of chronic severe limitation of adaptation and function in the home and outside environment. The worker is withdrawn, forgetful, unable to concentrate, needs continuous emotional support within the family setting and is incapable of self-care and neglects personal hygiene.

There may be an obvious loss of interest in the environment and the worker becomes extremely irritable, showing significant emotional

lability, changes of mood (near to a psychotic depressive level) and uncontrolled outbursts of temper. The worker may be severely depressed with outstanding features of psychomotor retardation and psychological regression. The worker is usually homebound or even roombound.

February 9, 1982
Bd. M.4951 #10

Source: Workers' Compensation Board, Board Policies & Administrative Directives.

A P P E N D I X 6

DIAGNOSTIC CRITERIA IN DSM-III

Diagnostic Criteria for Generalized Anxiety Disorder

A. Generalized, persistent anxiety is manifested by symptoms from three of the following four categories:

(1) motor tension: shakiness, jitteriness, jumpiness, trembling, tension, muscle aches, fatigability, inability to relax, eyelid twitch, furrowed brow, strained face, fidgeting, restlessness, easy startle;

(2) autonomic hyperactivity: sweating, heart pounding or racing, cold, clammy hands, dry mouth, dizziness, light-headedness, paresthesias (tingling in hands or feet), upset stomach, hot or cold spells, frequent urination, diarrhea, discomfort in the pit of the stomach, lump in the throat, flushing, pallor, high resting pulse and respiration rate;

(3) apprehensive expectation: anxiety, worry, fear, rumination, and anticipation of misfortune to self or others;

(4) vigilance and scanning: hyperattentiveness resulting in distractibility, difficulty in concentrating, insomnia, feeling "on edge," irritability, impatience.

B. The anxious mood has been continuous for at least one month.

Diagnostic Criteria for Dysthymic Disorder (or Depressive Neurosis)

A. During the past two years the individual has been bothered most or all of the time by symptoms characteristic of the depressive syndrome but that are not of sufficient severity and duration to meet the criteria for a major depressive episode.

B. The manifestations of the depressive syndrome may be relatively persistent or separated by periods of normal mood lasting a few days to a few weeks, but no more than a few months at a time.

C. During the depressive periods there is either prominent depressed mood (e.g., sad, blue, down in the dumps, low) or marked loss of interest or pleasure in all, or almost all, usual activities and pastimes.

D. During the depressive periods at least three of the following symptoms are present:

(1) insomnia or hypersomnia;
(2) low energy level or chronic tiredness;
(3) feelings of inadequacy, loss of self-esteem, or self-deprecation;
(4) decreased effectiveness or productivity at work or home;
(5) decreased attention, concentration, or ability to think clearly;
(6) social withdrawal;
(7) loss of interest in or enjoyment of pleasurable activities;
(8) irritability or excessive anger;
(9) inability to respond with apparent pleasure to praise or rewards;
(10) less active or talkative than usual, or feels slowed down or restless;
(11) pessimistic attitude toward the future, brooding about past events, or feeling sorry for self;
(12) tearfulness or crying;
(13) recurrent thoughts of death or suicide.

Diagnostic Criteria for Psychological Factors Affecting Physical Condition

A. Psychologically meaningful environmental stimuli are temporally related to the initiation or exacerbation of a physical condition.

B. The physical condition has either demonstrable organic pathology (e.g., rheumatoid arthritis) or a known pathophysiological process (e.g., migraine headache, vomiting).

Diagnostic Criteria for Conversion Disorder

A. The predominant disturbance is a loss of or alteration in physical functioning suggesting a physical disorder.

B. Psychological factors are judged to be etiologically involved in the symptom, as evidenced by one of the following:

(1) there is a temporal relationship between an environmental stimulus that is apparently related to a psychological conflict or need and the initiation or exacerbation of the symptom;
(2) the symptom enables the individual to avoid some activity that is noxious to him or her;

(3) the symptom enables the individual to get support from the environment that otherwise might not be forthcoming.

C. It has been determined that the symptom is not under voluntary control.

D. The symptom cannot, after appropriate investigation, be explained by a known physical disorder or pathophysiological mechanism.

E. The symptom is not limited to pain or to a disturbance in sexual functioning.

Diagnostic Criteria for Obsessive Compulsive Disorder

A. Either obsessions or compulsions:

Obsessions: recurrent, persistent ideas, thoughts, images, or impulses that are ego-dystonic, i.e., they are not experienced as voluntarily produced, but rather as thoughts that invade consciousness and are experienced as senseless or repugnant. Attempts are made to ignore or suppress them.

Compulsions: repetitive and seemingly purposeful behaviours that are performed according to certain rules or in a stereotyped fashion. The behaviour is not an end in itself, but is designed to produce or prevent some future event or situation. However, either the activity is not connected in a realistic way with what it is designed to produce or prevent, or may be clearly excessive. The act is performed with a sense of subjective compulsion coupled with a desire to resist the compulsion (at least initially). The individual generally recognizes the senselessness of the behaviour and does not derive pleasure from carrying out the activity, although it provides a release of tension.

B. The obsessions or compulsions are a significant source of distress to the individual or interfere with social or role functioning.

Diagnostic Criteria for Simple Phobia

A. A persistent, irrational fear of, and compelling desire to avoid, an object or a situation other than being alone, or in public places away from home (Agoraphobia), or of humiliation or embarrassment in certain social situations (Social Phobia). Phobic objects are often animals, and phobic situations frequently involve heights or closed spaces.

B. Significant distress from the disturbance and recognition by the individual that his or her fear is excessive or unreasonable.

Diagnostic Criteria for Agoraphobia

A. The individual has marked fear of and thus avoids being alone or in public places from which escape might be difficult or help not available in case of sudden incapacitation, e.g., crowds, tunnels, bridges, public transportation.

B. There is increasing constriction of normal activities until the fears or avoidance behaviour dominate the individual's life.

Diagnostic Criteria for Social Phobia

A. A persistent, irrational fear of, and compelling desire to avoid, a situation in which the individual is exposed to possible scrutiny by others and fears that he or she may act in a way that will be humiliating or embarrassing.

B. Significant distress because of the disturbance and recognition by the individual that his or her fear is excessive or unreasonable.

Diagnostic Criteria for Hypochondriasis

A. The predominant disturbance is an unrealistic interpretation of physical signs or sensations as abnormal, leading to preoccupation with the fear or belief of having a serious disease.

B. Thorough physical evaluation does not support the diagnosis of any physical disorder that can account for the physical signs or sensations or for the individual's unrealistic interpretation of them.

C. The unrealistic fear or belief of having a disease persists despite medical reassurance and causes impairment in social or occupational functioning.

Diagnostic Criteria for Post-traumatic Stress Disorder

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.

B. Reexperiencing of the trauma as evidenced by at least one of the following:

(1) recurrent and intrusive recollections of the event;
(2) recurrent dreams of the event;
(3) sudden acting or feeling as if the traumatic event were recurring, because of an association with an environmental or ideational stimulus.

C. Numbing of responsiveness to or reduced involvement with the external world, beginning some time after the trauma, as shown by at least one of the following:

(1) markedly diminished interest in one or more significant activities;
(2) feeling of detachment or estrangement from others;
(3) constricted affect.

D. At least two of the following symptoms that were not present before the trauma:

(1) hyperalertness or exaggerated startle response;
(2) sleep disturbance;
(3) guilt about surviving when others have not, or about behaviour required for survival;
(4) memory impairment or trouble concentrating;
(5) avoidance of activities that arouse recollection of the traumatic event;
(6) intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.

SUBTYPES:

Post-traumatic Stress Disorder, Acute

A. Onset of symptoms within six months of the trauma.

B. Duration of symptoms less than six months.

Post-traumatic Stress Disorder, Chronic or Delayed

Either of the following, or both:

(1) duration of symptoms six months or more (chronic);
(2) onset of symptoms at least six months after the trauma (delayed).

Diagnostic Criteria for Psychogenic Pain Disorder

A. Severe and prolonged pain is the predominant disturbance.

B. The pain presented as a symptom is inconsistent with the anatomic distribution of the nervous system; after extensive evaluation, no organic pathology or pathophysiological mechanism can be found to account for the pain; or, when there is some related organic pathology, the complaint of pain is grossly in excess of what would be expected from the physical findings.

Appendix 6

C. Psychological factors are judged to be etiologically involved in the pain, as evidenced by at least one of the following:

(1) a temporal relationship between an environmental stimulus that is apparently related to a psychological conflict or need and the initiation or exacerbation of the pain;

(2) the pain's enabling the individual to avoid some activity that is noxious to him or her;

(3) the pain's enabling the individual to get support from the environment that otherwise might not be forthcoming.

Source: American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Third Edition. Washington, D.C.: 1980.

A P P E N D I X 7

Directive 1. Guidelines For Claims Adjudication Involving Pre-Existing Conditions and Application Of The Second Injury and Enhancement Fund

ADJUDICATION OF CLAIMS INVOLVING PRE-EXISTING CONDITIONS

A) Temporary Disability

A claim for a work injury involving a pre-existing condition may be allowed for the acute episode only and entitlement to payment of compensation ceases when the worker's condition has reached the pre-accident stage. In a claim where there was a pre-existing condition but the worker is symptom free at the time of the compensable accident, there is no limitation of benefits throughout the period of temporary disability.

Some claims may be allowed for a "once only repair" as in the case of a strangulated hernia or recurrent shoulder dislocation. Allowance of a claim on this basis recognizes that a compensable accident did occur but that the resulting treatment and period of disability were due, at least in part, to the pre-existing condition.

If the period of disability as a result of the accident becomes prolonged due to the pre-existing condition, a portion of the compensation and medical aid costs may be transferred from the accident employer in Schedule I to the Second Injury and Enhancement Fund in accordance with the approved policy. There is no provision in the Act for such a Fund to apply to Schedule II employers.

B) Permanent Disability:

The presence of a pre-existing condition is reflected in any permanent disability award when the degree of residual disability found in such cases is increased owing to the underlying condition. Permanent disability awards to the worker and cost transfers from the accident employer (Schedule I only) are made in accordance with the approved criteria in the sections dealing with the aggravation of pre-existing conditions and Second Injury and Enhancement Fund application.

APPLICATION

The policy on aggravation of pre-existing conditions applies to both Schedule I and Schedule II claims in which:

1) a relationship is shown between an underlying condition and the degree of disability arising from the accident; and

2) the period of treatment and recuperation is prolonged due to an underlying condition; and/or

3) an increased degree of residual disability occurs over that usually found in such cases owing to the underlying condition.

Note: Both physical and psychological disabilities are included.

2.2 OTHER PRIOR CONDITIONS - APPLICATION TO WORKER AWARD

This category applies where a prior condition is not measurable but enhances the residual disability resulting from the accident.

2.2.1 Condition producing minor pre-accident disability -- award full assessment.

2.2.2 Condition producing moderate pre-accident disability -- award 75% of total assessment.

2.2.3 Condition producing major pre-accident disability -- award 50% of total assessment.

EXPLANATORY NOTES

The following applies to paragraphs 2.2.1 through 2.2.3.

a) No reduction should be made if the prior condition was the result of a prior compensable accident (unless 2.1 applies, i.e., an award for permanent disability was granted in a previous claim).

b) Pre-existing psychological disability would be assessed in terms of the limitations shown in the work record and social integration of the worker that have been produced by mental illness and/or defects of personality.

c) The significance of the pre-accident disability should be considered in terms of the likely clinical rating that would have been assessed if the pre-accident problem had been compensable, having regard to the range of disabilities usually encountered in such a condition.

2.3 OTHER PRIOR CONDITIONS - APPLICATION TO EMPLOYER COSTS

Financial relief to the Schedule I employer is accomplished by the application of S.I.E.F., if indicated. Different factors can apply in recommending relief for the employer as compared to what is appropriate for determining the award for the worker. Consideration must be given to the medical significance of the pre-existing condition and the severity of the accident as appropriate under the following table:

2.3.1 Pre-existing condition of minor significance

minor accident	50% cost transfer
moderate accident	25% cost transfer
major accident	0% cost transfer

2.3.2 Pre-existing condition of moderate significance

minor accident	75% cost transfer
moderate accident	50% cost transfer
major accident	25% cost transfer

2.3.3. Pre-existing condition of major significance

minor accident	90 to 100% cost transfer
moderate accident	75% cost transfer
major accident	50% cost transfer

Source: Workers' Compensation Board, Board Policies & Administrative Directives, passim.

A P P E N D I X 8

LENGTH OF DISABILITY CHART

FRACTURES	PERIOD
Finger, Simple	3 weeks
Finger, Compound	6 weeks
Metacarpal, Simple	6 weeks
Wrist (Carpus)	3 months
Wrist (Scaphoid)	
- uncomplicated	4 months
- complicated	6-18 months
Radius and Ulna	3 months
Colles	3 months
Humerus	6 months
Dislocation of Shoulder	6 weeks
Shoulder (Fractures/Dislocations)	6-12 months
Toes	3 weeks
Metatarsal	6-8 weeks
Mid-tarsal	3 months
Os Calcis and/or Talus	3-6 months
Tibia and Fibula	3-6 months
Tibia Alone	3-6 months
Fibula Alone	3-6 months
Ankle	2-6 months
Patella	8 weeks
Femur	6-9 months
Pelvis	6 months
Compression Fracture of Vertebra	3-6 months
One Rib	2-3 weeks
Multiple Ribs	3-6 weeks
Clavicle	2 months

FRACTURES INTO THE JOINTS	
Shoulder	6 months
Elbow	3 months
Wrist	3 months
Hip	6-9 months
Knee	6 months
Ankle	2-6 months

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Length of Disability Chart
(cont.)

FRACTURES	PERIOD
OTHER	
Head Injuries	Individual consideration
Bone and Skin Grafts	Individual consideration
Lacerations	Individual consideration
Laminectomy	3-6 months
Fusion of the back	4-8 months
Hernia repair	2 weeks prior to surgery and 6 weeks average following surgery
Arthroscopy where surgery is carried out	48 hours following the procedure
Arthroscopy where surgery is carried out through the scope	4-6 weeks
Myelogram or CT Scan	48 hours following the procedure

Source: Workers' Compensation Board, Claims Adjudication Branch Procedures Manual.

REFERENCES

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Third Edition. Washington, D.C.: 1980.

Culpan, R. & Taylor, C. Psychiatric disorders following road traffic and industrial injuries. Australian & New Zealand J. of Psychiatry. Vol. 7, No. 32, 1973.

Kassay, G. The New Organic and Non-Organic Combined Rating Approach: the Medico-Legal Interpretation. Presented at the Annual Meeting, Medical Directors of WCBs of Canada. Toronto: April 26, 1985.

Keiser, Lester. The Traumatic Neurosis. Toronto: J.B. Lippincott, 1968.

Select Committee on the Ombudsman. Fifth Report. Toronto: 1978.

Select Committee on the Ombudsman. Twelfth Report. Toronto: 1984.

Weighill, V.E. 'Compensation Neurosis': a review of the literature. J. of Psychosomatic Research. Vol. 27, No. 2, 1983.

Workers' Compensation Board. Board Policies and Administrative Directives.

Workers' Compensation Board. Claims Adjudication Branch Procedures Manual.

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Psychotraumatic entitlement

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